UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES

MEDICARE ANNUAL REPORT TO THE CONGRESS

Fiscal Year 1986

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The following reports contained in this volume:

- Medicare Annual Report
- Medicare/Medicaid Validation Survey of Hospitals Accredited by the Joint Commision on Accreditations of Hospitals Report

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MEDICARE

Medicare is a Federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people. Enacted into law in July 1965 and put into effect July 1, 1966, it is administered by the Health Care Financing Administration (HCFA). Local Social Security Administration offices take applications for Medicare, assist beneficiaries in filing claims, and provide information about the program.

Medicare has two parts -- hospital insurance and medical insurance. Hospital insurance helps pay for inpatient hospital care and certain followup care. Medical insurance helps pay for physicians and many other medical services and items.

Hospital insurance is financed through part of the Social Security (FICA) tax. Voluntary medical insurance is financed from the monthly premiums paid by people who have enrolled for it and from Federal general revenues.

PREFACE

The Health Care Financing Administration's Fiscal Year 1986 agenda continued to emphasize the Reagan Administration's policy of reforming health care financing programs in order to provide necessary health care to the Medicare population with enhanced efficiency and quality. Considerable attention was devoted during the year to formulating and implementing reforms designed to better serve Medicare beneficiaries while at the same time constraining costs through improving programs and stimulating competition in the health care industry.

During 1986, which marked the beginning of the third decade of Medicare and my installation in June as its fifth Administrator, enrollment and benefit expenditures continued to increase as they have each year since the program was introduced in 1966. Enrollment rose 2.1 percent to 31.75 million, and benefit outlays increased 6.5 percent to $74.036 billion. This placed increased demand on HCFA resources. However, intent on preserving essential benefits and services for the growing population of elderly and disabled beneficiaries, I adopted a number of goals to guide my tenure as Administrator and to chart salutary change.

As a physician, I am particularly committed to ensuring that beneficiaries receive quality care and are afforded additional options in health care services. Increased flexibility in the delivery of services is desirable not only to meet the assorted needs of beneficiaries, but also to promote competition among providers, which is essential to dampening inflation in medical costs. Furthering these goals will necessitate an aggressive research and demonstration program, strengthened provider performance incentives and oversight, adoption of new approaches to care, and a continuing informational campaign to make beneficiaries well-informed health care consumers.

Progress was made in each of these areas of concern during the year. For example:

- Major improvements were recorded in the operation of peer review organizations (PROs), which are engaged by HCFA to oversee the quality of care hospitals provide Medicare beneficiaries.

- More beneficiaries are enrolling in prepayment plans, such as health maintenance organizations (HMOs), which have the potential of saving Medicare money.

- Refinements and improvements have strengthened the prospective payment system for Medicare participating hospitals.

- HCFA intensified research into methods to better measure the quality of patient care, and at the same time, support a number of needed Medicare payment reforms.

- Better administrative practices have improved HCFA's ability to complete and issue program regulations and reports on a timely basis.

The report that follows will review in greater detail our actions to advance and attain these goals. While we have made significant progress, there will always be room for improvement as we strive to provide the best possible care to those who depend upon our services.

WILLIAM L. ROPER, M.D.
Administrator

ABBREVIATIONS USED IN THIS REPORT

AAPCC . . . Adjusted average per capita cost
ADP . . . Automatic data processing
ALICO . . . Amalgamated Life Insurance Company of America
BLS . . . Bureau of Labor Statistics
BPRP . . . Bill Payment Review Program
CABG . . . Coronary artery bypass grafts
CMP . . . Competitive medical plan
COBRA . . . Consolidated Omnibus Reconciliation Act
CPEP . . . Contractor performance evaluation program
CPI-U . . . Consumer price index for urban consumers
CPT-4 . . . Common procedural terminology, fourth revision
CWF . . . Common working file
DC . . . Data communications
DEFRA . . . Deficit Reduction Act
DRG . . . Diagnosis related group
EEO . . . Equal employment opportunity
EMC . . . Electronic media claim
ESRD . . . End-stage renal disease
FTE . . . Full-time equivalent
FSES . . . Fire safety evaluation system
FY . . . Fiscal year
GS/GM . . . General schedule/general merit
HCFA . . . Health Care Financing Administration
HCPCS . . . Health Care Financing Administration Common Procedural Coding System
HHA-RRP . . Home Health Agency Reimbursement Review Program
HHS . . . U.S. Department of Health and Human Services
HI . . . Hospital Insurance Trust Fund
HO-QUEST. . Home Office Quality Evaluation of Settlements Under the Tax Equity and Fiscal Responsibility Act
HMO . . . Health maintenance organization
HSR . . . Hospital-specific rate
ICD-9-CM. . International Classification of Diseases, Ninth Edition, Clinical Modification
IIC . . . Inflation-indexed charge
IPA . . . Individual practice association
IPRP . . . Interim Payment Review Program
JCAH . . . Joint Commission on Accreditation of Hospitals
LSC . . . Life Safety Code
MEI . . . Medicare economic index
MIGs . . . Medicare insured groups
MSP . . . Medicare secondary payer
NIH . . . National Institutes of Health
NTIS . . . National Technical Information Services
OHMO . . . Office of Health Maintenance Organizations
OPHC . . . Office of Prepaid Health Care
OQ . . . Office of Qualification
ORD . . . Office of Research and Demonstrations
PIP . . . Periodic interim payment
P.L. . . . Public law
PPS . . . Prospective payment system
PRISM . . . Project to redesign information systems management

ABBREVIATIONS USED IN THIS REPORT
(Continued)

PRO . . . Peer review organization
QUEST . . . Quality Evaluation of Settlements Under the Tax Equity and Fiscal Responsibility Act
R&D . . . Research and demonstrations
SA . . . State agencies
SMI . . . Supplementary medical insurance
SNF . . . Skilled nursing facility
SSA . . . Social Security Administration
TEFRA . . . Tax Equity and Fiscal Responsibility Act
TIPPS . . . Test of intermediary prospective payment settlements

MEDICARE POPULATION AND BENEFITS

Beneficiaries

During Fiscal Year 1986 the number of Medicare beneficiaries increased by approximately 667,000 from 31.083 million to 31.75 million (Tables 1 and 2). About 616,000 of the new beneficiaries were 65 years of age and older, bringing the number of elderly enrolled in Medicare to 28.8 million, and 51,000 were younger disabled persons, boosting the number of disabled beneficiaries to 2.9 million. Of the total number of beneficiaries, 31.090 million were residents of the United States, 409,131 lived in U.S. territories, and 250,000 resided in other countries.

Nearly 95 percent (27.3 million) of the aged and 92.2 percent (2.7 million) of the disabled were enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B). Approximately 96 percent of the Medicare enrollees residing in the United States were covered by both parts (Table 3).

Health Care Providers

At the close of the fiscal year, 5,994 short-stay and 217 long-stay hospitals with a total of 1.46 million beds were participating in Medicare, as were 6,897 skilled nursing facilities (SNFs), 96 comprehensive outpatient rehabilitation facilities, 5,978 home health agencies (HHAs), and 4,138 independent laboratories. Other participating health care providers included 574 ambulatory surgical centers, 268 hospices, 432 rural health clinics and 1,469 facilities or units providing services to Medicare beneficiaries requiring maintenance dialysis or kidney transplants.

Benefit Payments

Medicare benefit payments totaled $74.036 billion in FY 1986, or 6.5 percent more than the benefit outlay for the previous year. Benefits paid under the hospital insurance program (Part A) amounted to $48.867 billion, while those paid under the supplementary medical insurance program (Part B) totaled $25.169 billion. Ninety-four percent of Part A spending was for inpatient hospital care, while 4.5 percent went for home health care, and one percent for skilled nursing facility (SNF) care. The balance was spent on hospice care. Physician services and independent laboratory costs accounted for 76.5 percent, outpatient services for 19.6 percent, and home health care and prepayment plans for 4 percent of Part B spending.

Part A benefit payments to hospices increased 133 percent over FY 1985, rising from $15 million to $35 million, and Part B benefit payments to group practices rose 66.9 percent over the same period, from $571 million to $953 million.

Table 1. Nearly 32 million persons have some Medicare coverage: Proportion of high use groups rises.

Year	Total	Aged			Disabled		
		Total	85+ Number	85+ Percent	Total	ESRD only	All ESRD[1]
1986	31,750	28,791	2,932	10.2%	2,959	39	120
1985	31,083	28,176	2,861	10.2%	2,907	31	103
1984	30,455	27,571	2,778	10.1%	2,884	30	98
1980	28,478	25,515	2,410	9.4%	2,963	28	67
1973	23,545	21,815	1,699	7.8%	1,731	6	10
1966	19,109	19,109	1,183	6.2%	--	--	--

[1]Sum of aged with ESRD, disabled with ESRD, and those entitled because of ESRD only (2991).

Note: Numbers in thousands. Totals include enrollees residing in U.S., in territories and possessions and in foreign countries.

Table 2. Medicare touches more and more people: One out of eight has some Medicare coverage.

Year	U.S. resident population	U.S. Medicare population	Medicare as percent of resident population
1986	241,078	31,090	12.9%
1985	238,741	30,437	12.7%
1984	236,447	29,824	12.6%
1980	227,255	27,890	12.6%
1973	211,357	23,104	10.9%
1966	195,576	18,824	9.6%

Note: Numbers in thousands. Totals exclude enrollees residing in territories, possessions and in foreign countries.

Table 3. Almost 96% of the U.S. Medicare population is entitled to both HI & SMI.

Program coverage	All Areas			U.S.			Possessions & territories			Foreign Countries		
	Total	Aged	Disabled	Total	Aged	Disabled	Total	Aged	Disabled	Total	Aged	Disabled
HI &/ or SMI*	31,750	28,791	2,959	31,090	28,237	2,853	409	317	92	250	237	14
HI	31,216	28,257	2,959	30,558	27,705	2,853	408	316	92	250	237	14
SMI	30,590	27,863	2,727	30,278	27,603	2,675	265	217	49	46	43	4
HI & SMI	30,056	27,329	2,727	29,745	27,071	2,675	264	215	49	46	43	4
HI only	1,160	928	232	812	634	178	144	101	43	204	194	10
SMI only	534	534	a	533	533	a	1	1	a	a	a	a

Percentage distribution

Program coverage	All Areas			U.S.			Possessions & territories			Foreign Countries		
	Total	Aged	Disabled	Total	Aged	Disabled	Total	Aged	Disabled	Total	Aged	Disabled
HI &/ or SMI	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HI	98.3%	98.1%	100.0%	98.3%	98.1%	100.0%	99.6%	99.5%	100.0%	100.0%	100.0%	100.0%
SMI	96.3%	96.8%	92.2%	97.4%	97.8%	93.7%	64.8%	68.3%	53.0%	18.6%	18.1%	27.3%
HI & SMI	94.7%	94.9%	92.2%	95.7%	95.9%	93.7%	64.5%	67.8%	53.0%	18.5%	18.0%	27.3%
HI only	3.7%	3.2%	7.8%	2.6%	2.2%	6.3%	35.2%	31.7%	47.0%	81.4%	81.9%	72.7%
SMI only	1.7%	1.9%	0.0%	1.7%	1.9%	0.0%	0.4%	0.5%	0.0%	0.0%	0.0%	0.0%

* Unduplicated count of persons enrolled in one or both parts of the Medicare program.
[a] Less than 500.

Note: Numbers in thousands.

Program Funding

Ninety-two percent of the financing for Medicare Part A is derived from employment taxes paid by workers and their employers, and by self-employed individuals. The remainder comes from Federal general revenues and other sources. Part B is financed by three sources: (1) premium payments from enrollees (23 percent); (2) contributions from general revenues (72 percent); and (3) interest on balances in the Hospital Insurance Trust Fund (5 percent).

ENSURING QUALITY OF CARE

During FY 1986, Peer Review Organizations (PROs) under the aegis of HCFA concentrated on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). Major areas scrutinized by the PROs included hospital admissions, readmissions and transfers, accuracy of coding, and day and cost outlier cases. These and other oversight activities led to the rejection by Medicare of claims amounting to about $276 million during the fiscal year, or $125 million more than the cost of the PRO program for the year.

HCFA instituted regulatory reforms during the year that benefitted Medicare-certified hospitals by relieving them of unnecessary and burdensome requirements. The reforms were instituted to bring Medicare's survey and certification requirements into conformity with those delineated in the Institute of Medicine's report titled, Improving Health Care in Nursing Homes (Institute of Medicine. Washington, D.C.: National Academy Press, 1986). At the same time, HCFA worked to ensure the successful implementation of a new process for surveying the quality of long-term care provided by nursing homes.

ENCOURAGING COMPETITION AND CHOICE

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by expanding the availability of prepayment health plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). By the end of the fiscal year, 142 HMOs and CMPs had signed contracts with Medicare and were serving 735,600 Medicare beneficiaries (Table 4).

It was estimated that as a result of the increase in the number of certified prepayment plans, half of all Medicare beneficiaries now live in areas served by both a prepayment plan and fee-for-service providers.

To better serve prepayment plans interested in contracting with Medicare, the Office of Prepaid Health Care was created within HCFA on June 16, 1986, by merging HCFA's Office of Prepaid Operations and the Public Health Service's Office of Health Maintenance Organizations.

Table 4. Medicare contracts with HMOs/CMPs.

Type of contract	Contracts 9/30/85	Contracts 9/30/86	Enrollees 9/30/85	Enrollees 9/30/86	Total payments FY 86
TEFRA Risk	67	142[1]	364,397[2]	735,600	$1,365.9
Cost	53	45	137,265	133,596	$ 109.8
Other					
Old Risk	4	4	41,083	48,404	$ 72.5
Demos	9	8	11,773	28,047	$ 51.8
HCPP	41	36	624,646	615,934	$ 418.8

[1] Includes 15 contracts which have been signed, but for which no payment has yet been made. Includes 17 CMPs.

[2] Includes enrollment from seven Health Care Prepayment Plans (HCPPs) which have signed risk contracts.

Note: Dollars in millions.

Prospective Payment System Refinements

FY 1986 marked the third year of the prospective payment system (PPS), which was refined during the year in the following ways:

- Recalibration of diagnosis related group (DRG) weights using charge data from the Medicare Part A bill file.
- Revision of procedures for making DRG classification changes to allow greater flexibility and quicker administrative reaction to new medical findings and developments.
- Implementation of an HCFA wage index to overcome limitations of data from the Bureau of Labor Statistics.
- Revisions in criteria for rural referral centers.
- Changes in the reporting methods and type of data needed to determine the indirect medical education adjustment factor.
- Adjustment to the Federal portion of DRG payments for those hospitals meeting the definition of a disproportionate share hospital.

Adjustments, Exceptions and Exclusions from PPS

At the end of FY 1986, 515 psychiatric hospitals, 906 psychiatric units, 79 rehabilitation hospitals, 473 rehabilitation units, 93 long-term hospitals, and 55 children's hospitals in the United States, plus 61 hospitals in U.S. commonwealths and territories, were excluded from the PPS. There also was a temporary exclusion for 22 alcohol/drug specialty hospitals and 352 alcohol/drug distinct-part units. Another 363 sole community hospitals, 171 rural referral centers, 8 cancer treatment centers, and 4 hospitals under the Section 602(k) waiver provision were receiving special treatment under PPS.

Other Reimbursement Policy Issues

Final regulations implementing a new reasonable-charge screen for nonphysician services, called the inflation-indexed charge, were issued by HCFA during the year as was a final rule specifying the factors to be used in identifying cases in which the use of reasonable-charge methodology produces grossly excessive or deficient benefit claims.

In another area, the Agency implemented regulations limiting payments for clinical laboratory tests and for determining when Medicare is the secondary payer for beneficiaries and their spouses covered by employer health plans.

Other reimbursement policy changes included the adoption of a prospective payment system for low-volume, Medicare-certified SNFs. The cost limits for SNFs and home health agencies also were revised, and national criteria for the coverage of home oxygen under Part B were developed.

IMPROVED OPERATIONAL EFFORTS

Beneficiary Services by Carriers

During FY 1986, Medicare carriers handled 14,766,424 beneficiary inquiries, while Medicare intermediaries handled 1,501,531. In addition, carriers handled 5,674,315 provider inquiries.

Electronically Submitted Claims

More than 40 million intermediary and about 82 million carrier claims were transmitted electronically to Medicare during the fiscal year. This exceeded the year's goal for increasing the Agency's reliance on the more cost-effective electronic transactions.

Replacement Contractors

HCFA reviewed contractor performance over a 3-year period, and as a result of low performance ratings, Idaho Blue Cross, an intermediary, and Equitable New Mexico, a carrier, lost their Medicare contracts. Blue Cross of Oregon is the new intermediary for Idaho, and Aetna Life Insurance Company is now the carrier for New Mexico.

Contractor Performance Evaluation Program

The Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. Forty-five discrete payment-safeguard standards were applied during the year in evaluating intermediary performance in the areas of bill processing, medical review, and provider reimbursement, while 27 were used to measure carrier performance in the areas of claims processing and medical review. The percentage of contractors meeting or exceeding the standards increased from 88.4 in FY 1985 to 91.6 in FY 1986.

Reimbursement Review Programs

The reimbursement review programs are used to evaluate the audit and settlement activities of Medicare contractors for institutional reimbursement. The resulting scores of the programs are taken into account by the CPEP to develop an overall rating of a contractor's performance. The findings from the programs identified over $16.9 million in potential overpayments and recoveries and over $17.6 million in erroneous interim payments. The programs used by HCFA to carry out this function include the Home Health Agency Reimbursement Review Program (HHA-RRP), the Quality Evaluation of Settlements

under TEFRA (QUEST), the PPS Interim Payment Review Program, the Test of Intermediary Prospective Payment Settlements (TIPPS), special audits of Prospective Payment System cost reports, the PPS Bill Payment Review Program (BPRP), and the Home Office Quality Evaluation of Settlements under TEFRA (HO-QUEST).

Part B Quality Assurance Review

The Part B Quality Assurance Program was designed to provide an objective procedure for evaluating the performance of Medicare carriers in the processing of claims. During FY 1986, the mean carrier total payment/deductible error rate fell 0.2 percent from the previous year.

Operational Reviews

Operational reviews instituted during the year monitored physician reimbursement levels associated with coronary artery bypass grafts, cataract surgery, and the financial impact of the laboratory fee schedule. Operational reviews are designed to assess the need for policy and operational reforms in vulnerable policy areas.

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

Research, demonstration and evaluation projects were conducted during the fiscal year in the areas of hospital payment, physician payment, State programs for long-term care, alternative payment systems, program analysis and evaluation, quality and coverage, and beneficiary awareness and preventive care.

HCFA undertakes studies and demonstrations to develop ways to promote efficiency in the Medicare and other HCFA programs. They assess the impact of the programs on health care costs, program expenditures, beneficiary access to services, health care providers and the health care industry. These research and demonstration programs also test and evaluate alternatives to present reimbursement, coverage, eligibility and management policies of the Medicare program.

The Project to Redesign Information Systems Management (PRISM)

PRISM was intended to build a systems environment using modern automated data processing and data communications technology. This initiative will permit HCFA to control program costs more effectively. During FY 1986, HCFA began implementing PRISM by initiating a redesign of Agency systems using modern data base and software engineering concepts; converting the Health Insurance master file from tape to disk; installing a mainframe computer and numerous personal computers; and conducting a comprehensive study preparatory to formulating an office information strategy for the 1990s.

Systems Development

HCFA developed two important new automated systems that affect program operations nationwide. One enables HCFA to determine actual monetary amounts, processing times and decisions related to Part A considerations and beneficiary hearing appeals. The other enables HCFA to identify the actual amounts and causes of provider overpayments.

Equal Employment Opportunity

HCFA took action to correct any inequities in its employment of women and minorities. In the GS/GM 13-15 grade band, minority representation increased by 0.5 percent, while the number of women at this level rose by 1.7 percent. Transitional positions, which prepare lower-graded staff for professional positions through training and job experience, increased from 16 to 30 in FY 1986, and six additional handicapped persons were added to the staff.

LEGISLATIVE HIGHLIGHTS

Major new legislation affecting Medicare in FY 1986 included the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272) and the Balanced Budget and Emergency Control Act of 1985 ("Gramm-Rudman-Hollings", P.L. 99-177). COBRA provided for many changes in the Medicare program while Gramm-Rudman-Hollings would limit Medicare benefit and administrative outlays in the event the law's deficit reduction targets and deadlines are not met by Congress. Through a series of emergency acts, Congress continued, until the enactment of COBRA, both the physician-fee freeze and the hospital payment rate placed in effect in FY 1985.

Chapter I.

THE MEDICARE POPULATION AND BENEFITS

INTRODUCTION

Medicare was implemented in 1966 to provide individuals 65 years of age and older with health care insurance and, during its first year of operation, spent $1 billion to provide coverage for 19.5 million beneficiaries. Over the succeeding years benefits have been added and the coverage expanded to include certain younger disabled persons. These changes have contributed to annual increases in enrollment and, coupled with inflation, to yearly rises in benefit expenditures. These trends were no different in FY 1986 than in every year since the inception of Medicare. Medicare enrollment increased 2.1 percent during the fiscal year, from 31.083 to 31.75 million, and benefit outlays rose 6.5 percent, from $69.518 billion to $74.036 billion.

MEDICARE BENEFICIARIES

Approximately 667,000 individuals were added to the Medicare rolls during the year. Some 616,000 of the new enrollees were 65 years of age and older, bringing the number of elderly beneficiaries to 28.8 million, and 51,000 were younger disabled persons, increasing the number of disabled beneficiaries to 2.9 million. Included among the disabled were 39,000 with end-stage renal disease who must meet eligibility requirements different than those for other disabled beneficiaries.

Of the 31.75 million beneficiaries, 31.09 million were residents of one of the 50 States or the District of Columbia, 398,227 resided in Puerto Rico, 6,345 in the Virgin Islands, 3,255 in Guam, and 1,304 in American Samoa, the Northern Mariana Islands and other outlying areas. Another 250,000 resided in foreign countries. Nearly 96 percent of the U.S. Medicare population, 64.5 percent of the beneficiaries in U.S. territories, and 18.5 percent of the beneficiaries in foreign countries were enrolled in both Medicare Part A and Part B.

As shown on Table 5, women accounted for 57.8 percent of the total Medicare population and 60 percent of the eldest beneficiaries. Only 36.4 percent of the disabled enrollees were women. At 63.6 percent, the percentage of disabled beneficiaries who are men continued to increase. The percentage of men in this category has risen every year since 1980, while the percentage of aged who are men has decreased slightly over the same period of time.

Minorities represent a growing proportion of the Medicare population (Table 5). In 1986, 3.226 million Medicare enrollees were other than white. This represented 10.5 percent of the Medicare population, an increase of 0.2 percent over 1985, and 0.6 percent over 1980. The percentage of nonwhite beneficiaries increased both in the aged and disabled categories. However, while nonwhites made up only 9.6 percent of aged beneficiaries, minorities represented 18.9 percent of the disabled population.

Table 5. Women and minorities:
A growing proportion of the Medicare population.

Year	Sex				Race			
	Number		Percent		Number		Percent	
	Male	Female	Male	Female	White	Other	White	Other
				Total				
1986	13,406	18,344	42.2%	57.8%	27,592	3,226	89.5%	10.5%
1985	13,128	17,955	42.2%	57.8%	27,081	3,098	89.7%	10.3%
1984	12,874	17,580	42.3%	57.7%	26,578	3,000	89.9%	10.1%
1980	12,139	16,340	42.6%	57.4%	24,956	2,744	90.1%	9.9%
				Aged				
1986	11,525	17,266	40.0%	60.0%	25,237	2,678	90.4%	9.6%
1985	11,282	16,894	40.0%	60.0%	24,745	2,585	90.5%	9.5%
1984	11,044	16,526	40.1%	59.9%	24,252	2,498	90.7%	9.3%
1980	10,268	15,247	40.2%	59.8%	22,534	2,257	90.9%	9.1%
				Disabled				
1986	1,881	1,078	63.6%	36.4%	2,355	548	81.1%	18.9%
1985	1,846	1,061	63.5%	36.5%	2,336	513	82.0%	18.0%
1984	1,830	1,054	63.5%	36.5%	2,326	502	82.2%	17.8%
1980	1,871	1,093	63.1%	36.9%	2,422	487	83.3%	16.7%

Note: Numbers in thousands.

A significant demographic trend that has affected and will continue to affect Medicare is the increasing median age of beneficiaries (See Table 1, p. 2.). In 1973, 1.699 million beneficiaries, or 7.8 percent of the elderly population, were 85 and older. As of July 1, 1986, 2.932 million, or 10.2 percent of the aged population, were in the 85 and over category. The aging of the Medicare population is an important factor because older beneficiaries generally require more health care services than those in the 65 to 75 age group.

BENEFIT EXPENDITURES

Medicare benefit payments for the fiscal year totaled $74.036 billion, or about $4.5 billion more than for FY 1985. About 88 percent of the increase was attributable to higher hospital and physician charges recognized by Medicare. Other contributing factors included an increase in demand for hospital and medical services and greater utilization of more expensive health care technology. These demand and utilization patterns are expected to continue as the total number of beneficiaries and the number of those 75 years of age and older are increasing annually. Medicare benefit payments for FY 1986 were broken down as follows:

- Hospital Insurance (Part A)--$48.867 billion
- Supplementary Medical Insurance (Part B)--$25.169 billion

HOSPITAL INSURANCE

Part A spending, which was 2.4 percent higher than in FY 1985, was divided among its components as shown on Tables 6 and 8. Although spending grew in each of these areas, the rate of growth was far less in FY 1986 than in FY 1985.

Hospital Services

Of all purchases, hospital care accounted for the largest portion of Medicare spending in FY 1986. More than 60 percent of Medicare's total benefit expenditures, and 94 percent of Part A outlays, were for inpatient hospitalization costs. This was the case even though there was a reduction in the number of inpatient hospital admissions, discharges and days of care. Admissions were down 1.8 percent, discharges 3.8 percent and days of care 5.4 percent from the FY 1985 figures. Under Part A, beneficiaries are eligible for 90 days of inpatient hospital care in a benefit period. In addition, they are eligible for 60 "lifetime reserve days."

Skilled Nursing Facility Services

Medicare paid $568 million for SNF services in FY 1986, or about 0.2 percent more than in the previous 12 months. The cost of SNF services accounted for slightly more than 1 percent of Part A outlays during the year. Medicare beneficiaries are entitled to 100 days of covered care during a benefit period in a skilled nursing facility after an inpatient hospitalization of at least 3 consecutive days, provided certain conditions are met.

Home Health Services

The $2.222 billion spent on home health services during the fiscal year was 5.3 percent higher than in FY 1985 and accounted for about 4.5 percent of Part A spending. Part A covers home health visits with no prior hospitalization requirement. The care needed must include part-time or intermittent skilled nursing care, physical therapy or speech therapy, and the patient must be confined to home.

Hospice Services

The greatest percentage increase in any single category of Medicare spending during FY 1986 was for hospice care, which soared 133 percent, from $15 million in FY 1985 to $35 million in FY 1986. The rise was primarily due to the growing popularity of hospice care, which was first offered as a benefit in FY 1984. It accounted for $2 million in Medicare spending that year. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

SUPPLEMENTARY MEDICAL INSURANCE

Part B, which was 15.4 percent higher than in FY 1985, was broken down as shown on Tables 7 and 8. The largest increases, in terms of expenditures, were for physician and outpatient services.

Physician Services and Medical Supplies

Expenditures for physician services and medical supplies totaled $18.55 billion for the fiscal year (Table 7). This was 10.5 percent higher than the FY 1985 outlay and represented nearly 75 percent of Part B spending for the year. Part B pays 80 percent of Medicare-approved charges for medical services after an annual deductible of $75 has been met.

Outpatient Services

Medicare spending for outpatient services rose 26.2 percent over FY 1985, increasing from $3.903 billion to $4.925 billion (Table 7). Outpatient services provided by hospitals are covered under Part B.

Table 6. Components of Part A spending.

Benefit	FY 1985	FY 1986	Percent change
Inpatient hospital	$45,017	$46,042	2.3
Skilled nursing facility	567	568	0.2
Home health	2,111	2,222	5.3
Hospice	15	35	133.3

Note: Dollars in millions.

Table 7. Components of Part B spending.

Benefit	FY 1985	FY 1986	Percent change
Physicians and suppliers	$16,789	$18,553	10.5
Outpatient services	3,903	4,925	26.2
Group practice	571	953	66.9
Independent laboratory	492	694	41.1
Home health	53	44	-17.0

Note: Dollars in millions.

Group Practice Plans

Part B expenditures for group practice plans increased from $571 million in FY 1985 to $953 million in FY 1986, for a 66.9 percent change. This was the highest percentage increase of any component of Part B and reflects the increased number of Medicare beneficiaries enrolled in prepayment plans.

Independent Laboratories

Spending for independent laboratory services under Part B increased 41.1 percent over the year, from $492 million in FY 1985 to $694 million.

Home Health Care

A relatively small amount of home health care is provided under Part B. The $44 million spent in FY 1986 was $9 million less than in the previous year.

PROVIDERS

Hospitals

The number of participating hospitals in FY 1986 increased from 6,707 in FY 1985 to 6,720. The number of short-stay hospitals, however, continued to decline, dipping from 6,034 to 5,994. Psychiatric hospitals increased from 474 to 509 while other long-stay hospitals increased from 199 to 217 (Table 9).

The 3-year-old prospective payment system (PPS) continued to influence hospital utilization. Short-stay hospital admissions declined an estimated 2.8 percent for the year to 10.6 million following fall-off of about 5.5 percent in FY 1985 (Table 10). Reductions also were registered in the average number of discharges and days of care per 1,000 Medicare enrollees. In 1985, there were about 356 discharges per 1,000 beneficiaries. A year later the ratio was down to 343 discharges per 1,000 beneficiaries. Similarly, the 2,947 days of care per 1,000 enrollees in 1986 were 5.4 percent fewer than in 1985 and 25 percent fewer than in 1982 (Table 11). While not the only factor, PPS is thought to have significantly influenced these changes. After declining sharply in the previous 2 years, the average length of a hospital stay leveled off at about 8.5 days during the fiscal year (Table 12).

Skilled Nursing Facilities

The number of SNFs rose from 6,451 to 6,897 in FY 1986 (Table 13). Although there were nearly 1,000 more SNFs in FY 1986 than in FY 1984, the number of SNF beds declined by 80,000 over the 2-year period.

Table 8. Medicare benefit payments shift to Part B services.

Fiscal Year	Total Medicare	Total Hospital Insurance	Inpatient Hospital	Inpatient SNF	HHA	Hospice	Total Supplementary Medical Insurance	Physician and Independent Lab	Outpatient	HHA	GPPP
					Benefit Payments (in millions)						
1986	$74,036	$48,867	$45,754	$607	$2,471	$35	$25,169	$19,247	$4,936	$33	$953
1985	69,518	47,710	44,918	575	2,202	15	21,808	17,282	3,911	44	571
1984	60,934	41,461	39,093	525	1,841	2	19,473	15,449	3,530	29	465
1983	55,589	38,102	36,081	505	1,516	--	17,487	13,708	3,346	22	411
					Percent Distribution						
1986	100.0	66.0	61.8	0.8	3.3	<0.1	34.0	26.0	6.7	<0.1	1.3
1985	100.0	68.6	64.6	0.8	3.2	<0.1	31.4	24.9	5.6	.1	0.8
1984	100.0	68.0	64.2	0.9	3.0	<0.1	32.0	25.4	5.8	<0.1	0.7
1983	100.0	68.5	64.9	0.9	2.7	--	31.5	24.7	6.0	<0.1	0.7
					Benefit Payments Per Enrollee						
1986	$2,332	$1,565	$1,466	$19	$79	$1	$823	$629	$161	$1	$31
1985	2,237	1,560	1,468	19	72	0.5	727	576	130	1	19
1984	2,001	1,382	1,303	17	61	0.1	662	525	120	1	16
1983	1,851	1,288	1,219	17	51	--	604	473	115	0.8	14
					Percent Change in Benefit Payments from Prior Year						
1986	6.5	2.4	1.9	5.6	12.2	133.3	15.4	11.4	26.2	-25.0	66.9
1985	14.1	15.1	14.9	9.5	19.6	650.0	12.0	11.9	10.8	51.7	22.8
1984	9.6	8.8	8.3	4.0	21.4	--	11.4	12.7	5.5	31.8	13.1

Table 9. Decreasing demand results in leveling off of certified beds.

	1975*	1980*	1984*	1985*	1986*
Total Hospitals	6,773	6,777	6,675	6,707	6,720
Beds (thousands)	1,140	1,150	1,144	1,144	1,146
Beds per 1,000 Enrollees	51.7	46.7	42.6	42.5	40.9
Short-Stay	6,107	6,104	6,038	6,034	5,994
Beds (thousands)	902	991	1,023	1,027	1,026
Beds per 1,000 Enrollees	40.9	40.2	38.1	38.2	36.6
Psychiatric	385	408	433	474	509
Beds (thousands)	199	131	97	95	97
Beds per 1,000 Enrollees	9.0	5.3	3.6	3.5	3.5
Other Long-Stay[1]	281	265	204	199	217
Beds (thousands)	40	28	23	22	23
Beds per 1,000 Enrollees	1.8	1.1	0.9	0.8	0.8

* As of July 1.

[1] Beginning October 1, 1983 a number of short-stay pediatric, rehabilitation, and alcohol/drug hospitals were re-assigned non short-stay provider numbers and are included in this category for 1984, 1985, and 1986.

Table 10. Inpatient hospital admissions trend downward since FY 1983.

Fiscal Year	All inpatient hospital admissions and transfers		Short-stay hospital and excluded unit admissions		Short-stay hospital admissions only	
	Number	Percent change	Number	Percent change	Number	Percent change
1982	11,369	---	11,218	---	11,218	---
1983	11,841	4.2	11,702	4.3	11,702	4.3
1984	11,766	-0.6	11,618	-0.7	11,534	-1.4
1985*	11,200	-4.8	11,000	-5.3	10,900	-5.5
1986*	11,000	-1.8	10,800	-1.8	10,600	-2.8

* Estimated.

Note: Numbers in thousands.

Table 11. Decline in admissions and length of stay results in 26 percent decrease in days of care utilization rate since 1982.

Year	Rate per 1,000 Enrolled: Discharges Rate	Discharges Percent change	Days of care Rate	Days of care Percent change
1982	382	---	3,933	---
1983	392	2.6%	3,918	-0.4%
1984	383	-2.3%	3,537	-10.7%
1985*	356	-7.6%	3,106	-13.8%
1986*	343	-3.8%	2,947	-5.4%

* Estimated.

Table 12. PPS effect on length of stay levels off: Length of stay in non-waiver states up slightly in 1986.

	FY 1983	FY 1984	FY 1985	FY 1986 Prior grouping	FY 1986 Current grouping
All areas	10.0	9.1	8.6	8.6	8.6
Non-waiver states	9.5	8.6	8.0	8.2[1]	8.5[2]
PPS only	---	7.7	7.9	8.0	8.2
Waiver states	13.2	12.7	12.1	11.5[3]	10.9[4]
Outlying areas	9.1	8.7	8.4	8.0	8.0

[1] Based on grouping of original 46 non-waiver States and D.C.

[2] Includes utilization for MA & NY with original non-waiver States.

[3] Based on grouping of original 4 waiver States (MD, MA, NJ, NY).

[4] Based on grouping of current waiver States (MD & NJ).

Home Health Agencies

In FY 1986 there were 5,978 home health agencies, an increase of 300 over the previous year (Table 13). Their number has more than doubled since 1980.

Other Providers

The number of independent laboratories in FY 1986 increased by 158 to 4,138 (Table 13). There were 1,463 ESRD facilities, 96 comprehensive outpatient rehabilitation facilities, 574 ambulatory surgical centers and 268 hospices participating in Medicare (Table 13).

PROGRAM FUNDING

Under the Social Security Act, the Hospital Insurance and the Supplementary Medical Insurance Trust funds, which are sources of financing for Medicare, are administered by a board of trustees. The board is comprised of five members. Three members serve in an ex officio capacity: The Secretary of the Treasury, who by law serves as managing trustee of both funds; the Secretary of Labor; and the Secretary of Health and Human Services. Two public members are nominated by the President and confirmed by the Senate for 4-year terms. The Administrator of HCFA serves as secretary of the board.

The primary source of Part A financing (92 percent) is derived from payroll taxes paid by workers and their employers and by self-employed individuals. The remaining 8 percent comes from Federal general revenues for certain deemed-insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B is financed by three sources: (1) premium payments from enrollees, (2) contributions from general revenues, and (3) interest on trust fund reserves. The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act is set at 25 percent of program costs. In FY 1986, beneficiary premiums covered 23 percent, and government contributions 72 percent, of the cost of Part B. Interest on trust fund reserves covered the other 5 percent.

Table 13. Strong growth in providers of alternative care.

	1975*	1980*	1984*	1985*	1986*
Skilled Nursing Facilities	3,932	5,052	5,952	6,451	6,897
Beds (thousands)	287	436	530	N/A	449
Home Health Agencies	2,242	2,924	4,684	5,679	5,978
Independent Laboratories	3,048	3,447	3,801	3,980	4,138
ESRD Facilities	--	999	1,334	1,394	1,463
Outpatient Physical Therapy	117	419	791	854	907
Portable X-Ray	132	216	269	308	347
Rural Health Clinics	--	391	420	428	432
Comprehensive Outpatient Rehabilitation Facilities	--	--	48	72	96
Ambulatory Surgical Centers	--	--	155	336	574
Hospice	--	--	108	164	268

* As of July 1.

N/A: Not Available
--: Not Applicable

Chapter II.

ENSURING QUALITY OF CARE

INTRODUCTION

One HCFA priority in FY 1986 was to develop, demonstrate and evaluate methods for measuring the quality of care afforded Medicare patients by certified providers. The intent was to promote and ensure effective and efficient delivery of all necessary medical services to beneficiaries. As in past years, PROs were integral to the quality-assurance effort (Table 14).

PEER REVIEW ORGANIZATIONS

Background

PROs are charged by law to assure that services rendered to Medicare beneficiaries are medically necessary, are provided in the most appropriate setting -- for example, acute care hospital as opposed to a skilled nursing facility or a lesser level of care -- and meet professionally recognized standards of quality.

PRO reviewers (usually nurses) use criteria for review which are developed by local physicians to approve payment for cases which clearly meet acceptable standards and to refer questionable cases to PRO physician-reviewers. If, after review, the PRO physician-reviewer determines that there is a quality problem, the PRO will initiate corrective action. If the PRO physician-reviewer determines that the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial. Only a PRO physician-reviewer may deny a case, and denials may be made only after the attending physician has been given an opportunity to discuss the case with a PRO physician.

PRO Review Focus in FY 1986

During FY 1986, PROs concentrated on those areas where there were incentives for hospitals to circumvent PPS. Major areas of concern were these:

- Identification of quality problems with subsequent corrective action, including education of problem providers and physicians, intensified review and, ultimately, monetary penalties and exclusion from Medicare payments.
- Admissions, to assure that they are medically necessary and appropriate.
- Readmissions and transfers, to assure that patients were not discharged too soon or transferred unnecessarily.

Table 14. Hospitals under PRO review.

PRO area	Acute	Alcohol detoxification	Rehabilitation	Psychiatric	Total
Alaska	23	0	0	2	25
Alabama	128	0	2	6	136
America Samoa/ Guam	2	0	0	0	2
Arizona	72	0	0	6	78
Arkansas	94	0	3	4	101
California	483	2	4	41	530
Colorado	79	0	3	6	88
Connecticut	36	0	0	10	46
Delaware	7	0	1	2	10
District of Columbia	11	0	1	2	14
Florida	222	1	5	25	253
Georgia	170	0	0	20	190
Hawaii	21	0	1	2	24
Idaho	46	0	2	5	53
Illinois	236	0	3	14	253
Indiana	118	0	0	20	138
Iowa	128	0	0	4	132
Kansas	143	0	0	7	150
Kentucky	105	0	2	9	116
Louisiana	151	0	0	21	172
Maine	45	0	0	3	48
Maryland	55	0	0	11	66
Massachusetts	113	0	1	10	124
Michigan	198	0	3	9	210
Minnesota	171	0	0	6	177
Mississippi	116	0	1	3	120
Missouri	145	2	2	13	162
Montana	62	0	0	1	63
Nebraska	99	0	0	2	101
Nevada	27	2	0	5	34

Table 14. Hospitals under PRO review (continued).

PRO area	Acute	Alcohol detoxification	Rehabilitation	Psychiatric	Total
New Hampshire	28	0	1	4	33
New Jersey	94	0	6	12	112
New Mexico	49	1	2	5	57
New York	261	0	3	33	297
North Carolina	132	3	0	18	153
North Dakota	55	0	1	1	57
Ohio	195	0	1	20	216
Oklahoma	132	0	1	11	144
Oregon	73	2	0	6	81
Pennsylvania	228	0	15	30	273
Puerto Rico	57	0	0	1	58
Rhode Island	14	0	0	3	17
South Carolina	72	0	0	9	81
South Dakota	62	0	1	0	63
Tennessee	145	0	0	12	157
Texas	466	1	5	36	508
Utah	39	1	0	3	43
Vermont	16	0	0	2	18
Virginia	103	0	2	17	122
Virgin Islands	2	0	0	0	2
Washington	105	3	0	4	112
West Virginia	66	0	1	1	68
Wisconsin	140	4	1	15	160
Wyoming	27	0	0	3	30
Total	5867	22	74	515	6478

- Accuracy of coding, to assure that payments were appropriate for the diagnosis and procedure associated with the stay.

- Day and cost outlier cases, to assure that these long-stay or high-cost cases were medically necessary and appropriate and warranted additional payment.

HCFA contracts with PROs for the 1986-1988 contract cycle, some of which became effective during FY 1986, continue to require that PROs monitor providers to assure their compliance with the terms of PPS. In addition, the new contracts require PROs to place greater emphasis on quality-of-care reviews and to establish community outreach programs to better inform Medicare beneficiaries of their rights under Medicare and the purpose and function of PROs. Action was also taken to reduce the number of reviews required during the first 2 years of certification for hospitals performing at an acceptable level. This was done to permit the PROs to devote more time to monitoring hospitals requiring greater oversight.

PRO contracts cover review of all Medicare inpatient hospital admissions and services. Table 14 presents a listing of health care facilities in each PRO area as of September 30, 1986. The facilities are categorized by type of facility (general acute, alcohol detoxification, rehabilitation, and psychiatric).

PRO REVIEW PERFORMANCE

Quality Issues

From October 1985 to September 1986, PRO denials for inappropriate discharges and transfers occurred in 8,785 cases, as follows:

- Premature discharge of a patient that resulted in the readmission of the patient to the same hospital -- 4,279 denials.

- Readmission of a patient to a hospital for care that could have been provided during the first admission -- 2,779 denials.

- Inappropriate discharge of a patient from a PPS unit to a PPS-exempt unit in the same hospital -- 1,671 denials.

- Discharge of a patient from a PPS-exempt unit to a PPS unit in the same hospital -- 56 denials.

As of September 30, 1986, PROs had:

- Identified 3,812 cases in which a pattern of care was detected that caused concern or represented a single "gross and flagrant" episode.

- Sent 1,024 first notices and 126 follow-up notices to providers or physicians informing them of the possibility of sanctions.

- Excluded 1 provider and 20 physicians from the Medicare program, and imposed monetary penalties against 10 physicians as a result of PRO sanction activities.

Utilization and Savings

From October 1985 to September 1986, the average PRO screened approximately 52 percent of the hospital admissions of Medicare beneficiaries and determined that 2.9 percent were inappropriate and that payment should be denied. The estimated net savings to Medicare as a result of the denials (exclusive of claims paid under waiver of liability) was estimated at $222 million. This was in addition to the estimated $54 million savings to the program resulting from the denial of claims in outlier cases reviewed by PROs. These and other PRO oversight activities contributed to a 4.6 percent decrease in the rate of hospital admissions of Medicare patients during the first quarter of FY 1986 compared to the same period a year earlier.

Retrospective PRO reviews of all PPS cases dating from October 1985 to September 1986 showed that 4.4 percent were assigned the wrong diagnostic related group code. The review was performed to ensure that Medicare patients were being correctly classified in terms of their illness or injury so that Medicare would be billed only for necessary and appropriate care. Under PPS, hospitals are paid based on the average costs for treating a particular illness or injury.

Evaluation of 1984-1986 Contract Cycle

The contracts of 51 PROs expired between June and November 1986. Each group was evaluated to determine whether its service was sufficiently satisfactory to justify the noncompetitive renewal of its 2-year contract. Twenty-four were renewed on this basis.

In deciding which contracts to renew, HCFA developed and sent to each PRO a three-part set of self-evaluation criteria designed to measure the PRO's activities towards fulfillment of the following contractual obligations:

- Objective attainment.
- Performance of required activities.
- Contract management.

Each PRO completed and returned the self-evaluation to the appropriate HCFA regional office for validation by the staff, and was subsequently afforded an opportunity to respond to the findings. A panel of central and regional office staff was then convened to review the self-evaluation criteria set, data reports and the findings of the SuperPRO (the independent contractor which evaluates the decisions made by the PROs) and determine whether the performance of the PRO merited noncompetitive renewal. A determination that the performance of a PRO did not warrant noncompetitive procurement did not preclude it from participating in the competitive procurement process. Of the 27 PROs disapproved for noncompetitive renewal, 19 successfully competed for new contracts.

The PRO program cost Medicare $151 million in FY 1986. The facilities which were reviewed are listed in Table 15.

Table 15. FY 1986 reviews completed.

	Pre-admission	Admission	Total
Alaska	34	4,711	4,745
Alabama	68,901	153,344	222,245
American Samoa/Guam		681	681
Arizona	6,502	29,645	36,147
Arkansas	4,423	61,725	66,148
California	66,438	284,954	351,392
Colorado	2,625	33,312	35,937
Connecticut	87,066	45,643	132,709
Delaware	696	19,019	19,715
District of Columbia	747	11,977	12,724
Florida	6,738	252,481	259,219
Georgia	12,487	115,375	127,862
Hawaii	747	10,831	11,578
Idaho	117	14,090	14,207
Illinois	6,737	201,500	208,237
Indiana	4,866	126,667	131,533
Iowa	6,842	26,087	32,929
Kansas	6,998	68,004	75,002
Kentucky	71,828	32,563	104,391
Louisiana	1,348	57,351	58,699
Maine	154	25,648	25,802
Maryland	2,088	33,630	35,718
Massachusetts[1]	1,378	1,402	2,780
Michigan	32,361	89,250	121,611
Minnesota	29,421	96,829	126,250
Mississippi	1,241	59,091	60,332
Missouri	2,755	94,641	97,396
Montana	2,183	13,902	16,085
Nebraska	7,459	79,440	86,899
Nevada	1,578	7,449	9,027
New Hampshire	2,309	5,855	8,164
New Jersey	2,169	36,805	38,974
New Mexico	4,195	13,297	17,492
New York	25,144	11,926	37,070
North Carolina	9,690	88,773	98,463
North Dakota	2,661	14,641	17,302
Ohio	23,398	148,180	171,578
Oklahoma	26,325	72,308	98,633
Oregon	11,793	26,602	38,395
Pennsylvania	30,058	190,785	220,843
Puerto Rico	2,983	6,789	9,772
Rhode Island	232	15,741	15,973
South Carolina	466	2,873	3,339

[1] The Massachusetts PRO review level would have been higher if the original Massachusetts PRO contract had not been terminated on October 24, 1985.

Table 15. FY 1986 reviews completed (continued).

	Pre-admission	Admission	Total
South Dakota	3,461	16,810	20,271
Tennessee	90,503	83,499	174,002
Texas	33,245	334,710	367,955
Utah	30	15,570	15,600
Vermont	1,189	6,392	7,581
Virginia	11,544	111,789	123,333
Virgin Islands	--	557	557
Washington	1,464	55,501	56,965
West Virginia	2,940	25,797	28,737
Wisconsin	50,558	69,094	119,652
Wyoming	532	7,192	7,724
Total	773,647	3,412,728	4,186,375

SURVEY AND CERTIFICATION

Revised Conditions of Participation for Hospitals

The Federal regulations governing hospital participation in Medicare were revised in FY 1986 to make them better reflect current medical practices and to relieve hospitals of burdensome and unnecessary obligations. The revised conditions of participation were published on June 17, 1986, and interpretative guidelines were concurrently issued to assist surveyors in applying the new requirements when evaluating a hospital seeking Medicare certification. Although the requirements for accreditation by organizations such as the Joint Commission on Accreditation of Hospitals had improved, Medicare's conditions of participation for hospitals continued to reflect a number of detailed and prescriptive requirements which had been necessary when originally developed in the late 1960s, but were no longer useful.

Developing Enforcement Regulations

Regulations pertinent to the Medicare and Medicaid survey and certification processes were revised in accordance with the proposals contained in the Institute of Medicine's report titled, Improving Health of Care in Nursing Homes (Institute of Medicine. Washington, D.C.: National Academy Press, 1986). They change Federal enforcement requirements that State agencies and HCFA must follow in surveying and certifying nursing homes, and are expected to improve conditions for Medicare beneficiaries confined to these facilities.

Implementation of a New Long-Term Care Survey Process

In recent years, HCFA has sought to improve Medicare survey procedures so as to increase the Agency's ability to measure the quality of care received by Medicare patients. New outcome-oriented survey methods are being tested that focus on the type of care given by a nursing home, rather than on the process followed in providing the care or the related paperwork. HCFA performed a full range of activities during the fiscal year to ensure the successful implementation of a new long-term care survey process:

- Preparation of technical assistance documents and a revised methodology for sampling.
- Preparation of draft procedural and care guidelines to instruct State and Federal surveyors.
- Development of a Notice of Proposed Rulemaking providing a detailed description of the new survey process as ordered by a United States District Court in the case of Smith vs. Bowen.
- Active participation in the new long-term care survey process national training effort.

Other Outcome Oriented Survey Processes

HCFA training prepared surveyors for participation in a pilot test comparing the outcome-oriented survey process for end-stage renal disease (ESRD) facilities with the traditional survey process. The results of a field test of the outcome-oriented process survey in four States are being evaluated by a contractor to determine their validity and reliability.

HCFA also engaged a contractor during the year to develop and test outcome-oriented survey forms and processes for home health agencies.

Chapter III.

ENCOURAGING COMPETITION AND CHOICE

INTRODUCTION

One of HCFA's priorities in FY 1986 was to increase the options available to Medicare beneficiaries for the delivery of health care services and to make them better informed consumers of these services. The intent is to give Medicare beneficiaries the same range of health care choices that those under 65 have and, in doing so, generate increased competition in the health care industry as a means of containing costs.

Emphasis continued to be placed on providing Medicare beneficiaries with an option of enrolling in prepayment health plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). Such plans are increasing in popularity among Medicare beneficiaries as an alternative to the traditional fee-for-service system for the delivery of health care services. HCFA initiated several actions during the year to promote prepayment plans as an option and to accommodate the rising demand for enrollment in them.

PROGRAM MERGER

The Office of Prepaid Health Care (OPHC) was created June 16, 1986, by transferring the Office of Health Maintenance Organizations (OHMO) from the Public Health Service to HCFA and merging it with the Office of Prepaid Operations (OPO). Prior to the merger, OHMO administered the Federal qualification provisions of the Public Health Service Act, while OPO administered Medicare contracts with HMOs and other prepaid health care organizations. The centralization of these functions will facilitate the processing of documents filed by prepaid health care organizations seeking either Federal qualification under Title XIII or a contract to serve Medicare beneficiaries.

PROGRAM ACTIVITY

Medicare Contracts with HMOs/CMPs

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 allowed HCFA to contract with HMOs and CMPs on a prospective capitation payment basis for the provision of health care services to Medicare beneficiaries. Regulations to implement TEFRA were published in January 1985. HCFA signed the first "risk" contract with a prepayment plan in April 1985 and, by the end of FY 1985, had contracts with 65 prepayment plans covering 346,283 Medicare beneficiaries. Rapid expansion continued in this area over the next 12

months and, by the close of FY 1986, 142 prepayment plans were under contract with HCFA and serving 710,542 Medicare enrollees.

Under TEFRA risk contracts, HCFA pays HMOs and CMPs 95 percent of the Average Adjusted Per Capita Cost (AAPCC) rate for each Medicare enrollee. In addition to saving 5 percent on each beneficiary enrolled under a TEFRA risk contract, HCFA promoted enrollment in prepayment plans because they stress preventive care and offer special advantages to their enrollees. At little additional cost, members may receive an enhanced benefit package which includes more benefits than provided by traditional Medicare, as well as relief from claims forms, copayments and deductibles and an opportunity to receive managed and coordinated care.

Prepayment Plan Trends

- At the close of FY 1986, there were 419 Federally qualified HMOs in operation. Of these, 58 were staff models, 93 were medical group models and 268 were individual practice associations (IPAs). To obtain Federal certification, an HMO must meet the managerial, marketing, health services, structural, and financial requirements of the HMO Act. Failure to maintain these requirements can lead to revocation of Federal qualification.

- Enrollment in HMOs grew 22 percent from October 1, 1985 through September 30, 1986. A national total of 23 million people were enrolled in all Federally qualified HMOs as of September 30, 1986.

- OPHC's Office of Qualification (OQ) handled 230 qualification applications in FY 1986. One hundred seventy-four of the 230 were applications submitted during the fiscal year. Fifty-six were applications in process at the end of the previous fiscal year. One hundred and sixteen received qualification, 4 were denied qualification and 34 withdrew their applications. Seventy-six applications were pending at the end of the fiscal year.

- OPHC received 19 CMP eligibility applications during FY 1986. These organizations were seeking to become eligible to contract with HCFA under the provisions of TEFRA. Eighteen CMPs were found eligible, and one expansion request was approved during the fiscal year.

- The OPHC Office of Qualification installed a "focused review" system to reduce the qualification application requirements for well-established HMO companies seeking to expand. The modified review system enabled the office to set new records for productivity.

- There was a 119 percent increase over FY 85 in the number of organizations which signed contracts with HCFA to provide services to Medicare beneficiaries on a TEFRA risk basis. Enrollment of Medicare beneficiaries in prepayment plans holding TEFRA risk contracts increased about 102 percent.

- Disenrollment from TEFRA risk contracts averaged 2.5 percent per month. Transfers to other risk contractors accounted for two-thirds of all disenrollments. HCFA worked closely with the Social Security Administration to ensure the timely processing of monthly enrollments

and disenrollments. Expeditious action was necessary to avoid any unnecessary interruption in protection for Medicare enrollees making this election and to ensure that HMOs received prompt reimbursement for the appropriate number of beneficiaries on their rolls.

Legislation Implemented

During the fiscal year, OPHC implemented three provisions of COBRA which expanded protections for Medicare beneficiaries enrolled in HMOs and CMPs. First, OPHC began reviewing and approving all marketing materials used by plans to ensure that beneficiaries would be adequately informed about the extent and terms of their health care coverage before and after joining a prepayment plan. Second, OPHC shortened the waiting period for beneficiaries wanting to withdraw from a plan. Under the new procedure, beneficiaries may disenroll effective the first day of the month following their request. Third, mandated quality assurance reviews of ambulatory care provided by HMOs and CMPs were started.

Besides these legislatively mandated changes, OPHC began implementation of a significantly strengthened oversight program for prepayment plans contracting with Medicare. A detailed on-site review protocol was developed for use by HCFA staff to monitor all plans regularly.

Initiative to Create Medicare Insured Groups

Work commenced on planning a demonstration program to expand Medicare risk contracting to employers who provide health benefits to their retirees. Under the Medicare Insured Groups (MIGs) demonstration, an employer or union would receive a monthly capitation for each Medicare beneficiary that enrolled in the employer's managed care plan. The employer would then assume medical and financial responsibility for providing both Medicare benefits and health benefits to its retirees. The employer or union would be paid 95 percent of the group's estimated Medicare costs, based on prior utilization. HCFA developed several technical assistance documents and held a series of meetings with employers, insurers and unions to discuss the concept. A number of large groups such as Amalgamated Life Insurance Company of America (ALICO) and Chrysler expressed strong interest in the program.

Initiative to Promote Quality Health Care in HMOs/CMPs

The following steps were taken to ensure quality health care:

- Draft guidelines for internal quality assurance programs of HMOs and CMPs were developed and circulated throughout the industry for comment. These guidelines significantly upgrade the quality assurance standards for HMOs and CMPs.

- HCFA formed a task force to plan the implementation of an external quality review of HMOs and CMPs under contract with Medicare.

- Efforts were undertaken to secure congressional approval to allow organizations other than PROs to conduct external quality reviews of HMOs and CMPs holding Medicare risk contracts.

OTHER INITIATIVES TO ENHANCE CONSUMER KNOWLEDGE

Beneficiaries Aided in Health Care Decision Making

HCFA disseminated to Social Security Administration (SSA) district offices instructions relevant to the COBRA provisions (which are detailed in Chapter VII) affecting the Medicare program. By mobilizing resources of HCFA and SSA, the Agency made readily available to the public information detailing changes made in Medicare by COBRA. This aided beneficiaries in making critical decisions about the level and nature of their health care insurance.

Distribution of Participating Physician/Supplier Directories

In August 1986, about 31 million notices were mailed to Medicare enrollees announcing the availability of directories listing the names of physicians and suppliers who participate in Medicare. The directories were distributed through local Social Security offices, senior citizen organizations and area Agency on Aging offices.

Chapter IV

EFFICIENT OPERATION OF MEDICARE

INTRODUCTION

As the costs of the Medicare program continue to outpace the overall rate of inflation, it becomes increasingly imperative for HCFA to redouble efforts to contain costs to ensure the financial integrity of the program and maintain the quality and level of beneficiary services. Following are selected highlights of agency initiatives pursued during the past fiscal year to improve the efficiency and cost-effectiveness of Medicare.

PROSPECTIVE PAYMENT SYSTEM (PPS) REFINEMENTS

FY 1986 marked the third year of PPS which was introduced for the purpose of promoting efficiency in the delivery of hospital services and slowing the rate of growth in hospital costs for Medicare patients. Under PPS, each hospital is paid a predetermined fixed rate based on the average costs for treating a particular illness or injury. These various illness categories are called DRGs. A patient's DRG classification is based on the principal diagnosis, the presence of comorbid or complicating conditions, procedures performed, and age, sex and discharge status.

Attention was devoted during the year to refining PPS and implementing changes mandated by the Consolidated Omnibus Reconciliation Act (COBRA). The following major modifications of PPS provisions became effective May 1, 1986.

Recalibration of DRG Weights Since the PPS payment in each case is determined, in part, by multiplying the standardized rate by the relative weight of the DRG into which the case falls, the setting of the relative weight (calibration) for each group is of critical importance in paying each hospital an appropriate amount for the resources used in each case. In recalibrating the DRG weights for FY 1986, it was decided to use the charge data from the Medicare Part A bill file.

Changes in the DRG Classification System The procedures for making DRG classification changes were revised to allow greater flexibility and quicker administrative reaction to new medical findings and developments. Changes were made to permit corrections of serious omissions or inequities and classification of newly covered items or services.

Development of a New Hospital Wage Index The 1983 PPS legislation required the development of a hospital wage index to adjust for the variation in wages in different areas when determining prospective payments to hospitals. A new wage index devised by HCFA was implemented May 1, 1986. It replaced an index based on hospital wage and employment data obtained from the Bureau of Labor Statistics (BLS), which did not accurately reflect area wage differences.

HCFA conducted a separate wage survey to obtain all the pertinent data on hours and developed these statistics to provide the basis for the new wage index used to calculate prospective payments to hospitals.

One-Year Extension of Transition to National DRG Rates COBRA extended the transition to fully Federal PPS rates for 1 year, except for hospitals in Oregon (which went to fully Federal PPS rates). COBRA continued the hospital-specific rate (HSR) and Federal rate blend at 50 percent each for the first 7 months of a hospital's cost-reporting period beginning in FY 1986. However, beginning with the eighth month of the hospital's FY 1986 cost-reporting period, the blend changed to 45 percent HSR and 55 percent Federal. The national/regional proportion within the Federal rate continued at 25 percent national and 75 percent regional through September 30, 1986.

Rate of Increase in Payments COBRA extended the FY 1985 payment rates through April 30, 1986, and provided for an increase of 0.5 percent in the PPS rates for the last 5 months of FY 1986. The hospital-specific portion increased by 0.5 percent, effective with the last 5 months of hospital cost-reporting periods beginning in FY 1986. For PPS exempt hospitals, COBRA provided for an increase to the target rate limits of 5/24ths of 1 percent for cost-reporting periods beginning during FY 1986.

Referral Center Criteria Regulatory reforms were effected during the year that changed the way rural referral centers calculate their case-mix index thresholds. The centers are now required to develop the data based on the Federal fiscal year.

Indirect Medical Education Factor Several changes were made in the reporting methods and type of data needed to determine the indirect medical education adjustment factor used in making payments to PPS hospitals. In addition, as a result of COBRA, the indirect teaching adjustment factor was reduced from 11.59 percent, paid on a linear basis, to 8.1 percent, paid on a variable or curvilinear basis, for discharges occurring on or after May 1, 1986.

Disproportionate Share Hospital Adjustment Effective with discharges occurring on or after May 1, 1986, COBRA provided for adjustments to the Federal portion of DRG payments for those hospitals that meet the definition of a disproportionate share hospital as prescribed in the law. This provision is intended to provide higher payments for hospitals that serve disproportionate numbers of low-income patients.

Adjustments, Exceptions and Exclusions from PPS

Several types of hospitals and hospital units are excluded from PPS. These include psychiatric, long-term care, children's and rehabilitation hospitals as well as psychiatric and rehabilitation units operating as distinct parts of acute care hospitals. Hospitals located outside the 50 States and the District of Columbia are also excluded. As of the end of FY 1986, 509 psychiatric hospitals, 906 psychiatric units, 79 rehabilitation hospitals, 473 rehabilitation units, 92 long-term hospitals, 55 children's

hospitals and 61 outlying area hospitals were excluded from PPS. An additional temporary exclusion was authorized by regulation for both alcohol/drug specialty hospitals and alcohol/drug distinct-part units of acute care hospitals. Twenty-two hospitals and 352 units have received such temporary exclusions.

Excluded facilities and units continue to be paid on the basis of reasonable cost subject to the rate-of-increase ceiling which limits Medicare payment for hospital inpatient operating costs per discharge to a target percentage increase over the preceding period's costs.

In addition, as of September 30, 1986, 363 sole community hospitals, 171 rural referral centers, 8 cancer treatment centers and 4 hospitals under the Section 602(k) waiver provision of P.L. 98-21 were receiving special treatment under PPS.

OTHER REIMBURSEMENT POLICY ISSUES

Reasonable Charge Screens for Nonphysician Services.

Medicare's use of reasonable charges to determine reimbursement for physicians' services and other services covered by Part B of the program has been criticized as inherently inflationary because actual charges, which increase steadily, are one of the bases for calculating reasonable charges. As a control on the rate of increase in Medicare payments for physicians' services, increases in prevailing charges (recognized for Medicare reimbursement) are limited to amounts that are justified by appropriate economic index data. On the other hand, year-to-year increases in charges for other Part B services, supplies and equipment are not controlled.

Final regulations, which were effective October 1, 1985, implement a new reasonable charge screen for nonphysician services known as the inflation-indexed charge (IIC). The IIC is defined as the lowest of the previous year's reasonable charge screens, updated by an inflation adjustment factor. The reasonable charge screens include the prevailing charge, customary charge, lowest charge level or the prior year's IIC. The inflation adjustment factor is determined by the change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending June 30.

Inherent Reasonableness

Medicare Part B reasonable charge determinations are generally based on customary and prevailing charges derived from historic charge data. This standard method of determining reasonable charges occasionally results in payments that are not justifiable. This may occur, for example, when the marketplace is not truly competitive because of limited suppliers, or when the Medicare program is the primary source of payment for a service. These situations may require the use of other factors or payment limits to ensure that charges are reasonable.

A final rule with comment period, published in the Federal Register on August 11, 1986, specifies the factors to be used in identifying cases in

which use of the reasonable charge methodology produces charges that are grossly excessive or deficient. The final rule also sets forth the factors to be used in establishing limits where charges are considered far out of line. Under that final rule, HCFA is required to publish any proposed national special limit as a notice in the Federal Register and provide an opportunity for public comment. When Medicare carriers propose local special limits, they will publish a notice in their newsletters and provide an opportunity for public comment.

Limits on Payments for Clinical Diagnostic Laboratory Tests

Clinical diagnostic laboratory tests performed in independent laboratories or physicians' offices and for outpatients of hospitals are reimbursed on the basis of fee schedules established for each Medicare carrier's service area. Those schedules have often produced wide variances in payment for clinical laboratory services across the country.

To lessen those differences, COBRA requires national limitations on payments for clinical diagnostic laboratory tests rendered on or after July 1, 1986. A provision has been implemented setting the national limit at 115 percent of the median of the fee schedule amounts all carriers have established for a test. Payment is based on the lowest of three figures -- the actual charge, the fee schedule amount or the national limit.

Implementation of the Medicare Secondary Payer Provision for the "Working Aged"

The statutory secondary payer requirements were intended to shift the cost of providing coverage for employed individuals and spouses age 65 and over from Medicare to private insurance companies. During FY 1986 HCFA issued regulations and instructions which contain rules for determining when Medicare is secondary payer and the amount it is to pay in those instances. They also specify the obligations of employers and group health plans to pay primary benefits for employed beneficiaries and spouses age 65 and over and to reimburse Medicare where it has improperly paid primary benefits.

Issuance of the regulations and instructions facilitated implementation of the Medicare Secondary Payer (MSP) program and promoted compliance with it in the private sector, thereby advancing the Agency's cost-savings objectives. The program saved Medicare more than $1.2 billion in FY 1986. At a cost of $39.5 million, the program's cost/benefit ratio was 25 to 1. In addition, FY 1986 marked the beginning of the MSP outreach program. The purpose of outreach is to prevent the submission of improper Medicare primary claims by providing affected groups and individuals with guidelines to help them identify cases in which Medicare is the secondary payer, so that claims are directed to the appropriate primary payer before they become Medicare claims. Savings will be realized directly, through decreased program expenditures, and indirectly, through reduced claims processing costs.

Payment for Skilled Nursing Facilities and Home Health Agencies

A prospective payment system for low-volume skilled nursing facilities

participating in Medicare was implemented under the authority of Section 1888(d) of the Social Security Act. This payment system took effect for cost reporting periods beginning on or after October 1, 1986. Prospective payment rates were published, and revised payment rates will be issued annually.

Skilled nursing facility cost limits were revised effective for cost reporting periods beginning on or after May 1, 1986, and published in the Federal Register on April 1, 1986. Revised home health agency cost limits were issued effective for cost reporting periods beginning on or after July 1, 1986, and before July 1, 1987. The new limits were published in the Federal Register on May 30, 1986.

Criteria for Coverage of Home Oxygen

HCFA developed and published in the Federal Register final national criteria for the coverage of home oxygen under the Part B durable medical equipment benefit. In addition to the Federal Register notice, the information was published as manual instructions and distributed to Medicare contractors, effective October 1, 1985, with a phase-in period of 12 calendar months. Before national criteria were promulgated, Medicare contractors independently developed and applied their own coverage criteria and related documentation requirements for determining when valid medical need for home oxygen therapy existed and could be reimbursed under Medicare Part B. The absence of uniform national coverage criteria resulted in widely varying coverage decisions by contractors on supplier and beneficiary claims.

With the implementation of national criteria, Medicare beneficiaries and suppliers of oxygen are now assured that all medically appropriate uses of home oxygen and related equipment will be treated uniformly and consistently by contractors in making coverage determinations.

Coordination of Medical Coding Issues

HCFA developed and tested an ongoing methodology for clarifying and updating the current Common Procedural Terminology, Fourth Revision (CPT-4) index and established an index for the Health Care Financing Administration Common Procedural Coding System (HCPCS) codes not included in CPT-4. HCFA also played a major role in supporting the American Hospital Association Coding Clinic and the International Classification of Diseases Clinical Modification (ICD-9-CM) Coordination and Maintenance Committee. This coordinated effort culminated in the publication of new ICD-9-CM procedure codes which resulted in an estimated annual savings of $50 million.

IMPROVED OPERATIONAL EFFORTS

Home Health Review

HCFA has improved the accuracy, consistency and uniformity of fiscal intermediary home health determinations. This was achieved through quarterly meetings with regional home health intermediaries to produce uniform and

accurate Medicare coverage decisions on home health claims, by developing instructions for outpatient physical therapy, speech therapy and audiology claims and by implementing home health concurrent authorization pilot projects at two intermediary sites. HCFA's efforts reduced inappropriate payment for ineligible home health services.

Beneficiary Services by Carriers

HCFA continues to emphasize to Medicare carriers the importance of providing local and toll-free telephone service to Medicare beneficiaries. Carriers are required to meet busy-signal and call-acknowledgment standards for telephone service. Additional funding was provided to carriers to install telephone monitoring equipment to electronically audit telephone service performance. Monthly reports of performance are required and action is taken to improve the performance of any carrier not in compliance with the standards.

During FY 1986, Medicare carriers handled 14,766,424 beneficiary inquiries (11,921,407 telephone, 2,390,096 written, and 454,421 walk-in). Carriers also handled 5,674,315 provider inquiries (3,125,657 telephone, 2,535,620 written, and 13,038 walk-in). Medicare intermediaries handled 1,501,531 beneficiary inquiries (1,073,106 telephone, 373,343 written, and 55,082 walk-in).

Electronic Media Claims

During the fiscal year more than 40 million intermediary claims and approximately 82 million carrier claims were received electronically. HCFA's goal was to increase the percentage of electronic media claims (EMCs) to 62 percent for intermediaries and 26 percent for carriers. By the end of FY 1986, intermediary and carrier EMCs reached 66.5 percent and 28.4 percent, respectively. The cost of processing the EMCs was about $49 million less than what it would have cost to handle the same number of paper claims.

Carrier Medical Review

Carriers are responsible for ensuring that a Medicare payment is made only for services that are medically necessary. Carriers are saving over 10 program dollars for each administrative dollar expended. Total savings for FY 1986 were almost $700 million.

Replacement Contractors

Section 2326 of The Deficit Reduction Act of 1984 (DEFRA) provided for the replacement of up to two fiscal intermediaries and two carriers through competition of their service areas based on their performance over time against established cost and performance criteria. The Contractor Performance Evaluation Program (CPEP) comprises the criteria and standards used to determine which contractors will be subject to replacement.

In FY 1986, the DEFRA rankings reflected contractor performance over a 3-year period. Idaho Blue Cross, an intermediary, and Equitable-New Mexico, a carrier, were ranked in the lowest 20th percentile, and as a result, their

carrier, were ranked in the lowest 20th percentile, and as a result, their service areas were put up for competitive bid. Blue Cross of Oregon is the new intermediary for Idaho, and Aetna Life Insurance Company is the carrier for New Mexico. The replacement contractors have efficiently and effectively performed the full range of services and activities required of a Medicare contractor.

Contractor Performance Evaluation Program

CPEP incorporates numerous performance standards designed to reduce inappropriate expenditures through payment safeguards. In FY 1986, 45 discrete payment safeguard standards were employed to evaluate intermediary performance in the areas of bill processing, medical review and provider reimbursement. Twenty-seven payment safeguard standards were used to evaluate carrier performance in the areas of claims processing and medical review. Selected standards included Medicare secondary payer goals, cost-effective medical review and audit programs, detection of fraud and abuse cases, limiting the incidence of provider overpayments and ensuring that no payments are made to excluded, terminated or suspended providers or physicians.

Of all payment safeguard standards reviewed for all contractors, FY 1986 reflected an improvement from 88.4 percent passing to 91.6 percent passing.

Common Working File

In FY 1986, HCFA implemented the first pilot testing of the Common Working File (CWF) initiative. This project improves the agency's ability to detect and avoid duplicate payments, reduces costly post-payment adjustments and overpayment recoveries, provides an efficient process for identifying inappropriate billing for bundled services (for example, services included in hospital DRG payments) and provides many possibilities to improve payment safeguards and beneficiary services.

REIMBURSEMENT REVIEW PROGRAMS

Numerous programs were conducted during the fiscal year that reviewed different aspects of Medicare reimbursement. These reimbursement review programs identified an estimated $11.1 million in recoveries and overpayments and reductions of $14.8 million in interim payments. The following are brief summaries of HCFA's reimbursement review programs.

Home Health Agency Reimbursement Review Program (HHA-RRP)

The HHA-RRP evaluates the quality of audits and settlements of HHA provider cost reports performed by Medicare intermediaries. Scores are recorded and used in the CPEP to develop an overall rating for contractor performance. During FY 1986, 38 intermediaries were evaluated under the HHA-RRP through the review of 39 provider cost reports. The estimated total dollar recoveries resulting from the program exceeded $135,000.

Quality Evaluation of Settlements Under TEFRA (QUEST)

The QUEST program evaluates the quality of intermediary performance in reviewing, auditing, adjusting and settling cost reports for hospitals excluded from PPS. During FY 1986, 57 intermediaries were evaluated using QUEST through the review of 180 provider cost reports. The estimated dollar recoveries exceeded $1.5 million. The scores from this program are used in the CPEP to develop an overall contractor rating.

Home Office Quality Evaluation of Settlements Under TEFRA (HO-QUEST)

HO-QUEST evaluates the quality of the intermediaries' performance in conducting audits of home office cost statements. During FY 1986, 28 reviews were completed with potential program overpayments discovered of over $975,000. While the scores from this program were not used in the CPEP evaluation this year, they will be included in the overall evaluation of contractors in FY 1988.

PPS Interim Payment Review Program (IPRP)

The PPS-IPRP monitors and evaluates the intermediaries' performance in calculating and adjusting PPS interim payment rates for hospital providers. The consequence of intermediaries making erroneous interim payments is the loss of interest to the Hospital Insurance Trust Fund for overpayments and a cash flow shortage to hospitals for underpayments. Medicare overpayments and underpayments are adjusted at the end of each hospital's fiscal year when settlement is made on the provider's submitted cost report.

Test of Intermediary's Prospective Payment Settlements (TIPPS)

TIPPS measures the intermediaries' performance in reviewing, auditing and settling hospital cost reports under PPS. During FY 1986, 51 intermediaries were evaluated under this program through the review of 82 provider cost reports. As a result of this program, a total of $6.3 million was identified as potential overpayments. In addition, the scores of this program were included in the CPEP to develop an overall contractor evaluation.

Special Audits of Prospective Payment System Cost Reports

Due to an urgent need for audited PPS cost report data from the first year of PPS, a special audit was conducted by the intermediaries to obtain the data. A special oversight program was developed to monitor the intermediaries' work and report on the quality of the audits performed.

More than $8 million in potential overpayments and over $4 million in reported cost errors were found through application of the review program. In addition, over $1.8 million of adjustments were made to cost reports in States not subject to PPS requirements. The main finding from the reviews was that incorrect medical education costs were being claimed by providers.

PPS Bill Payment Review Program (BPRP)

The BPRP monitors and evaluates the intermediaries' performance in calculating payments for Medicare PPS bills submitted by hospitals. This review program did not disclose any significant problems with intermediary performance in calculating and paying provider PPS bills. However, the program provides a sentinel effect to ensure proper handling of accounts. In addition, HCFA can assure the beneficiaries that proper payments are being made on their behalf.

Part B Quality Assurance Review

The Part B Quality Assurance Program was designed to provide a statistically valid and objective procedure for evaluating carrier claims processing performance. The data generated constitute an integral part of the CPEP. A national quarterly report is published which ranks carriers based on the cumulative error rates assessed during the most recent 12-month period. Carriers are ranked both on the occurrence error rate (processing errors per 100 line items in the universe) and on the payment/deductible error rate (dollar errors per 100 dollars of submitted charges in the universe).

FY 1986 results were as follows:

- Thirty-one Medicare Part B carriers (44 processing sites) processed 251 million claims with submitted charges totaling $34 billion. Normally 37 carriers (51 processing sites) operate Medicare Part B, but not all submitted data promptly.

- Carrier occurrence error rates ranged from 0.7 percent to 14.5 percent for a mean occurrence error rate of 6.4 percent.

- Carrier payment/deductible error rates ranged from 0.6 percent to 3.6 percent. The mean payment/deductible error rate was 1.6 percent.

- Projected dollar errors were estimated at $225 million in overpayments, $175 million in underpayments, and $25 million in deductibles.

During FY 1986, the mean payment/deductible error rate and the mean carrier error rate for carriers fell 0.2 percent from the previous year. The national overpayment error rate, based on 44 of 51 carrier locations reporting, was 0.9 percent. This indicates that $0.90 was estimated to be overpaid per $100 of submitted charges. For FY 1985, this error rate was 0.9 percent.

This program enabled HCFA to assess carrier claims processing performance, evaluate carrier compliance to mandatory payment policy, furnish statistically valid performance results, use these results for determining carrier contract renewals and ranking carrier performance, and initiate corrective action plans to resolve identified carrier deficiencies.

Operational Reviews

Operational reviews are conducted to assess the need for policy and operational reforms in vulnerable program areas. The objective of the FY 1986 operational reviews was to research and develop changes for existing payment formulas and programs in order to improve the efficiency of the Medicare and Medicaid programs, increase competition in the medical marketplace, increase access to care and achieve budget savings.

During FY 1986, as part of HCFA's efforts in support of payment reform, operational reviews were conducted in several areas:

- Coronary Artery Bypass Grafts (CABG) - This review was conducted to study physician reimbursement levels associated with CABGs. This study gathered data to determine if physician reimbursement levels were appropriate given the technological and productivity changes that have occurred in the last decade. The vast amount of data that was gathered will be compiled and analyzed in FY 1987.

- Cataract Surgery - This study determined that the insertion of an intraocular lens which is an integral part of most cataract procedures adds very little time to the length of the procedure. At the same time, however, the fee charged for this insertion increases the cost of the procedure approximately 50 percent.

- Laboratory Fee Schedule Study - This study focused on the financial impact of the Laboratory Fee Schedule mandated under DEFRA and found that the implementation resulted in no savings to Medicare.

Debt Collection

It is HCFA's policy to seek collection of all monies it is owed. However, special efforts are taken to ensure that beneficiaries' rights are protected while pursuing debt-collection activities. HCFA collects debts through the use of offsets (reductions against current or future payments) whenever possible. During FY 1986, HCFA began to use credit reports on a nationwide basis, to determine the financial ability of debtors to repay the government, and recovered $685 million in actual monies and adjustments. This procedure is expected to enhance future debt collection activities.

Development of Automated Systems

HCFA developed an automated system in FY 1986 that enables it to manage the actual amounts and causes of provider overpayments and associated interest, the recoupments and the times associated with recovery. This system utilizes a nationwide telecommunications network linking HCFA's central office with its regional offices and fiscal intermediaries.

HCFA also developed an in-house testing capability during the year that makes it possible for HCFA systems designers and managers to simulate the processing of claims by a carrier. This facility has resulted in a marked increase in productivity for programming end-of-line quality assurance systems, and has provided the basis for a complete systems modernization effort in Part B quality control.

Chapter V.

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

INTRODUCTION

For a substantial period of time, the costs of health care services have been outpacing the rate of inflation in the general economy. This means that not only has the absolute number of dollars spent on health care increased rapidly, but also the proportion of the Gross National Product related to health care has increased. This trend continues to be a matter of primary concern to HCFA as the leading purchaser of health care in the United States. Since the establishment of HCFA in 1977, the overall purpose of its research and demonstration (R&D) program has been to find ways to moderate or control this inflationary trend and to ensure that every dollar is used effectively in the service of HCFA beneficiaries.

HCFA's R&D activities provide knowledge to enable the Administrator, the Secretary, Congress and other interested parties to make informed and rational decisions regarding HCFA program and policies.

HCFA's existing research, demonstration and evaluation activities include projects to test new reimbursement, coverage, eligibility and program management approaches as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to quality health care services and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing research and demonstration activities. These projects result in knowledge about the basic structure, incentives, costs and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis and develop innovative financing and delivery systems.

In addition to its intramural projects, HCFA spent almost $29 million for grants and contracts to conduct research, demonstration and evaluation projects during the fiscal year. The seven program areas addressed were: Alternative Payment Systems, Quality and Coverage, Physician Payment, Hospital Payment, Program Analysis and Evaluation, Beneficiary Awareness and Prevention and State Programs for Long-Term Care. More specific information on individual projects can be found in the Health Care Financing Status Report: Research and Demonstrations in Health Care Financing (U.S. Department of Health and Human Services. HCFA 03253. Washington, D.C.: Government Printing Office, 1986).

ALTERNATIVE PAYMENT SYSTEMS

Prior research and demonstration activities involving the Medicare program focused primarily on HMOs. This work determined that alternative delivery systems and alternative risk reimbursement mechanisms are

cost-effective and offer Medicare beneficiaries the opportunity for improved benefits over the existing fee-for-service system. With the implementation of TEFRA HMO provisions, there was a need to go beyond HMO and CMP models and test other delivery and financing systems that enhance competition among providers and yield potential savings to the program.

This involves several other areas such as hospital payment, physician payment and State programs for long-term care. However, projects tend not to be limited to one segment of the Medicare population or to one aspect of the health care delivery and financing system. Within this area, researchers attempt to identify, test and evaluate cost-effective alternative delivery and/or financing systems which affect multiple segments of the program. Therefore, the agency focused on those projects designed to test systems capitating payments for various types of services and those projects which tried to refine or test alternatives to the current methods and bases for payments to capitated systems.

Thirty-five studies that have tested alternative reimbursement methods continued in FY 1986. For example, HCFA continued evaluations of the most recent series of HMO demonstrations and began planning for an evaluation of the TEFRA HMO and CMP programs.

The following ongoing demonstrations all test various innovative concepts:

- A reimbursement method which considers the beneficiaries' prior use of Medicare services as an additional factor in the adjusted average per capita cost (AAPCC) methodology.
- Three HMOs located in competitive marketing areas receive reimbursement at 85 percent of the AAPCC, rather than the TEFRA-mandated 95 percent.
- The social health maintenance organization concept studies a capitated delivery and financing system that integrated health and social services under the direct management of the provider of services.
- Competitive models for clinical laboratory services and durable medical equipment were designed as an alternative to the current financing system.

QUALITY AND COVERAGE

Program changes have the potential to impact on the quality of care provided to program beneficiaries. In order to assess the impact of such changes, as well as to ensure continued access by program beneficiaries to quality care, it is essential that valid quality of care measures for different treatment settings be developed. For this reason HCFA funded two new quality and coverage studies in FY 1986:

- A Proposed Study to Assess the Impact of PPS on the Quality of Long-Term Care in Nursing Homes and Home Health Agencies (Center for Health Services Research). This project will examine patient-level process indicators of the quality of care provided to skilled nursing facility and home health agency patients before and since

implementation of PPS. The project will then assess pre- and post-PPS differences in patient care practices and outcomes and make recommendations to further assess the impact of PPS on long-term care. The study will help address the allegations that patients are discharged "quicker and sicker," leading to a decline in quality care.

- The Causes of Failure to Transplant Cadaveric Human Organs (Brandeis University). This project will attempt to determine the reasons for the high rate (19.6 percent) of wastage of cadaveric kidneys in the United States and make recommendations to reduce their loss. This study could help the efficiency of the organ procurement system.

Because expansion of Medicare coverage to include new benefits or services may also affect program expenditures and quality of care, it is imperative that HCFA continue to study selected coverage issues to determine the extent of any such impact. It is equally important that it continue to study the potential impact of new technologies on treatment and service utilization for particular segments of the Medicare population. The agency has 31 studies in progress, including ones in the following areas:

- Survival rates of end-stage renal disease patients, particularly focusing on the impact of treatment modalities on survival rates.

- The effects of expanded coverage of alcoholism and mental health services.

PHYSICIAN PAYMENT

Physician research has been refocused to study ways to refine current methods of paying physicians. In spite of efforts to constrain physician payment by extensions of the fee freeze, the physician component of the economy continued to grow faster than the overall economy.

Ten extramural studies begun prior to FY 1986 continued into the fiscal year. These studies, along with three intramural studies, focused primarily on refinements to the current payment system for physician services. The short-run research priorities emphasized understanding physician involvement in the first year of the Medicare participating provider program and physicians' perception of the impact of the Medicare PPS on their inpatient hospital practices. Intermediate-term research studied payment methods for certified registered nurse anesthetists and the impact of the fee freeze; it also sought to understand and identify overpriced procedures. Longer-range research efforts stress the study and development of refinements in the way HCFA pays for physician services.

Although progress has been made on reducing the rate of growth in spending for Medicare physicians' services, there is still cause for concern. During FY 1986, Part B benefit outlays grew at a rate of over 15 percent. And even though the freeze on physicians' customary and prevailing charges temporarily controlled the price of services, growth of utilization and

intensity still remains an issue. HCFA's physician research agenda parallels concerns about the growth in Medicare spending for Part B services and will provide information for physician payment reform.

HOSPITAL PAYMENT

Concurrent with ongoing Congressionally mandated studies on various features of the PPS, HCFA has examined various types of acute care in the interest of developing alternatives to hospital care. These efforts are of major importance to the Medicare program in terms of cost-effectiveness and quality of care and services. In FY 1986 HCFA funded two new extramural hospital payment research studies:

- A DRG-Based Case Mix Analysis of Oncology Care in Comprehensive Cancer Centers, Teaching Hospitals and Community Hospitals (Brandeis University). This project will analyze large, national data bases to compare patient characteristics and treatment settings. In addition, 2,000 Medicaid records will be individually abstracted to gather data on inpatient stays and related outpatient care. The data and analysis will help develop a refined case-mix classification system that builds in substitutions and efficiencies affected by the shift of oncology care to outpatient settings.

- DRG Refinement and Diagnostic Specific Comorbidities and Complications: A Synthesis of Current Approaches to Patient Classification (Yale University). This project will investigate whether the relationship between selected diagnoses and hospital utilization depends on the presence of other diagnoses. It also seeks to make recommendations to modify the current diagnosis-related groups using diagnostic-specific comorbidities and complications to define the more complex types of patients with high levels of utilization.

Besides these new studies, 40 other extramural hospital payment projects, which were begun in prior years, continued into FY 1986. These studies, which were discussed in greater detail in earlier annual reports, focus on a range of hospital payment issues that includes inpatient general, outpatient, hospital prospective payment, case mix, home health, hospice and skilled nursing facility prospective payment.

Intramural research work has extended into hospital malpractice insurance, costs of disproportionate-share hospitals (low-income and Medicare patients), analyses of skilled nursing facility patient classification groups, analyses of the financial performance of hospitals under PPS, analyses of the PPS outlier payment methodology, analyses of the indirect teaching adjustment formula, incorporation of capital costs into the prospective payment system and alternative methods for recalibration of DRG weights.

PROGRAM ANALYSIS AND EVALUATIONS

Congress has prompted major changes in the past few years to improve the effectiveness and efficiency of the Medicare program. Research on and evaluation of these changes, as well as on factors influencing program performance, provide the information on health care expenditures and utilization patterns of Medicare beneficiaries necessary to achieve more cost-effective program operations. Essential to this effort is the improvement of existing Medicare data bases.

Several aspects of program performance have been studied to improve understanding of them. Factors influencing utilization of particular types of services and the characteristics of certain categories of beneficiaries were examined. Among the ongoing projects, specific activities included the following:

- Study of post-surgical mortality of beneficiaries to understand better the factors influencing survival rates.
- Study of geographic variation in medical use and costs to understand better factors influencing utilization patterns and costs of services.
- Study of the "cross-over" population that uses Medicare and Medicaid, to understand better the characteristics of this segment of the Medicare/Medicaid population.

PREVENTIVE CARE

Current coverage rules governing Medicare do not allow reimbursement for most preventive services. HCFA, however, continues to maintain an interest in the potential beneficial effects of particular preventive medical services through its research.

Eleven previously initiated studies continued in FY 1986, including two 6-year Medicare prevention demonstrations. The 11 studies were funded as a result of a special solicitation that was published in 1983.

STATE PROGRAMS FOR LONG-TERM CARE

It is expected that the costs of long-term care will continue to grow. Because the Federal government shares in the funding of these costs, it shares the States' particular interest in State- and locality-developed projects to design and test alternatives to the current long-term care delivery and financing systems. In response to the increasing demand for these services, HCFA and the States are gaining a better understanding of the existing long-term care population and exploring non-traditional approaches toward caring for the elderly in the community.

In general, HCFA's long-term care research activities utilize existing data, either collected by survey or abstracted from other data sources. The research focuses primarily on describing and explaining the demand for such care and the basic economic underpinnings of the long-term care industry. In addition, considerable effort is devoted to developing a methodology to measure the quality of long-term care provided in different settings. This research was developed to provide an understanding of long-term health care delivery, reimbursement and financing systems in order to provide some direction for private and public policy decisions and to identify promising areas for demonstration activities.

In FY 1986, HCFA funded two new demonstrations in this area:

- Design, Implementation, and Evaluation of a Prospective Case Mix System for Nursing Homes in Massachusetts (Commonwealth of Massachusetts). This project will design, implement and evaluate a prospective case-mix system for a random sample of nursing homes in Massachusetts. Its goal is to develop and test incentives for nursing homes to admit and treat heavy-care patients while ensuring quality care.

- The New York State Integrated Quality Assurance System for Residential Health Care Facilities: The Next Step After Case Mix Reimbursement (State of New York). This study will develop and test a patient oriented quality assurance system that links Federal and State utilization control and survey and certification processes with nursing home reimbursement. This will permit comparison of the present survey system, HCFA's new patient care and services survey process, and the New York system to determine the relative effectiveness of each.

Forty-three studies initiated in prior years continued during FY 1986. The Agency continued to develop data and information bases that provide a deeper understanding of the aged population and its social (family, community, financial) setting and permit analysis and policy and research simulation. In the National Medical Expenditure Survey, cosponsored by HCFA and the National Center for Health Services Research, particular attention is being given to understanding the spend-down process whereby persons in nursing homes exhaust their financial resources to qualify for Medicaid.

This survey will also permit evaluation of the differential access to long-term care services by Blacks and Hispanics. In addition, HCFA worked with States to identify, develop, demonstrate and evaluate cost-effective alternative payment and delivery systems that ensure beneficiaries' continued access to quality long-term health care. Previously initiated evaluations of demonstrations including the evaluation of the long-term care channeling demonstrations, also were continued.

Chapter VI.

PROMOTING IMPROVEMENTS IN HCFA

INTRODUCTION

During the fiscal year, HCFA made major improvements intended to promote efficiency. Many of these improvements were in the data processing area, while others affected administrative and personnel policies practices. Following are some of the more significant improvements introduced during the fiscal year.

THE PROJECT TO REDESIGN INFORMATION SYSTEMS MANAGEMENT (PRISM)

PRISM was initiated to develop a computer system that incorporates modern automated data processing (ADP) and data communications (DC) technology. Such a system will help the Agency control program expenditures more effectively, analyze critical issues more rapidly and assume additional program responsibilities with diminishing administrative resources.

HCFA took the following steps to create PRISM:

- Efforts were begun to redesign Agency systems using modern data base and software engineering concepts. The Health Insurance (HI) master file was converted from tape to disk at the Social Security Administration's National Computer Center using a modern data base management system. This was done to streamline the updating process, provide more timely beneficiary information for claims processing, save significant amounts of computer time and simplify software maintenance. Also, development of a prototype of future Medicare ADP systems was begun; plans for a total redesign of HCFA's ADP systems over a 3- to 5-year period were approved by the Department of Health and Human Services; and a number of projects were started to enhance existing systems in the interim.

- A large mainframe computer (IBM 3081) and a number of disk storage devices were installed and put into operation at the HCFA Data Center. This additional processing and on-line data storage capacity was used to increase significantly the level of ADP support for quality-of-care monitoring, Medicare contracts administration, and program analysis. Also at the HCFA Data Center, a new system for the management of disk storage was implemented to ensure the efficient use of this resource; an ADP action desk was established to assist users with day-to-day operations; and plans were made to obtain additional computer capacity for anticipated needs.

- Two hundred and twenty-five personal computers were procured and installed in HCFA's offices nationwide to improve access to data and increase productivity through automation. An information desk for personal computer users was established, and a major study was

conducted to formulate an office automation strategy for HCFA well into the 1990s. A data communications strategy is also being developed to address current and future requirements.

- Training was provided to approximately 1,200 employees at the central office and in the regions to ensure their appropriate and productive use of Agency equipment and resources. Specialized training was given to ADP personnel to enhance their skills in the use of the latest software development techniques.

- A HCFA Data Dictionary program was established to ensure appropriate, consistent use of statistical information for program reporting and analysis. Entry of data on the Medicare Statistical System, HCFA's primary source of information on Medicare enrollment and utilization, was begun.

DEVELOPMENT OF AUTOMATED SYSTEMS

HCFA developed two important automated systems in FY 1986, both of which are online, real-time, and utilize a nationwide telecommunications network linking HCFA central and regional offices with each other and with Medicare fiscal intermediaries. One system enables HCFA to determine actual monetary amounts, processing times and decisions relative to Part A reconsiderations and hearing appeals filed by or for the beneficiary. Through this system, management is able to access and utilize pertinent data to control the efficient handling of beneficiary requests and to assess the performance of fiscal intermediaries in the process.

HCFA developed another automated system that enables it to manage the actual amounts and causes of provider overpayments and associated interest, the recoupment of monies and the times associated with recovery. Data can be accessed at remote sites and used to provide statistics to assess Part A fiscal intermediary operations.

PART B CLAIMS PROCESSING SIMULATION

An in-house testing capability was developed during the fiscal year that makes it possible for HCFA systems designers and managers to simulate the processing of claims by a carrier. This capability has resulted in a marked increase in productivity for programming end-of-line quality assurance systems and has provided the basis for a complete systems modernization effort in Part B quality control.

AUTOMATED PERSONNEL SYSTEM

All subsystems comprising the HCFA Comprehensive Personnel System were converted during the year from the Datapoint 1660 to the IBM 4341, Model 204 Database Management System. The subsystems are:

- Employee Master File
- Classified Position System
- SF-52 Tracking System
- Awards Tracking System
- Training Management Information System
- Separated Employee File.

HCFA's automation capabilities were upgraded in August 1986 with the addition of an Employee Qualifications System to the Comprehensive Personnel System stored in the IBM 4341. Employee qualification data for the previous two years were input into the system.

PROCUREMENT GOALS

The Department of Health and Human Services set procurement preference and competition goals for FY 1986. A summary of the departmental procurement goals and HCFA's actual performance is shown on Table 16.

EQUAL EMPLOYMENT OPPORTUNITY (EEO) ACCOMPLISHMENTS

HCFA made great strides during the fiscal year in three major EEO areas of concern (Table 17). In the GS/GM 13-15 grade band, minority representation increased by 0.5 percent and the number of women by 1.7 percent. In a second area, transitional positions which are geared toward preparing lower-graded staff for movement into professional positions through formal training and job experience, the number held by minorities and women increased from 16 in FY 1985 to 30 in FY 1986. In the third area, an additional six individuals with handicapping conditions also were hired during the fiscal year by the Agency. Although modest, these gains met or exceeded the goals established for women and minorities and further indicated HCFA's determination to assure equality in employment. It is noteworthy that they were achieved during a period when the total work force was decreasing.

Much of the success in attaining EEO goals is attributable to the implementation of several innovative techniques. For example, the Equal Opportunity Office, in cooperation with the other HCFA offices, developed affirmative action plans which identified and targeted specific underrepresented groups for recruitment. These plans required managers to evaluate their respective work forces from an equal-employment-opportunity perspective and to recruit qualified candidates for the purpose of increasing the number of minority and women employees in job areas where they were underrepresented. HCFA also developed and conducted a training program for managers which stressed pertinent aspects of EEO, such as discrimination and

the affirmative action process. Additionally, the Equal Opportunity Office worked closely with the Personnel Office to identify HCFA employees and individuals in the private sector who could be recruited under the affirmative action plan to increase representation of specific groups in certain employment areas.

EMPLOYEE FITNESS CENTERS

Early in the fiscal year HCFA opened outdoor and indoor fitness facilities as part of its "Fit for Life" program designed to promote employee health and fitness. The indoor fitness center features state-of-the art exercise equipment and a specially designed aerobics exercise area.

Table 16. HCFA's procurement goals and performance.

Category	Dollar goal	Percent goals	Actual performance
Small business	$ 15,050,000	50%	64.27%
8(a)	8,025,000	25%	34.25%
Direct minority	301,000	1%	0.32%*
Women-owned business	1,625,000	5%	9.70%
Labor surplus areas	1,605,000	5%	9.41%

*Because there is no mandated set-aside authority for direct awards to minority firms, achievement of this goal depended primarily upon the minority marketplace submitting proposals for and winning competition awards.

Table 17. Equal employment opportunity accomplishments.

	FY 1986	FY 1985
GS/GM 13-15 grade band		
Minorities	12.5%	12.0%
Individuals with handicapping conditions	0.8%	Not available
Transitional positions		
Minorities	33.3%	31.3%
Individuals with handicapping conditions	0.0%	6.3%

Chapter VII.

LEGISLATIVE HIGHLIGHTS

Major new legislation affecting HCFA and Medicare in FY 1986 included COBRA, the Balanced Budget and Emergency Control Act of 1985 (Gramm-Rudman-Hollings) and various measures extending controls on physician and hospital charges.

Gramm-Rudman-Hollings established annual deficit reduction targets for balancing the Federal budget by 1990 and provided for an automatic sequestration of funds if the targets are not met. Under sequestration, Medicare benefit payments would be reduced 1 percent in FY 1986 and 2 percent annually in succeeding fiscal years, and administrative costs would be subject to the full across-the-board cuts (4.3 percent in FY 1986).

In an effort to contain Medicare costs, Congress approved a series of emergency extension acts to maintain the freeze on physicians fees until the enactment of COBRA. Hospital charges also were held at the FY 1985 level by these extension laws.

Another money bill winning congressional approval, the Urgent Supplemental Appropriations Act of 1986 (P.L. 99-349), delayed for 1 year the incorporation of capital-related costs into the Medicare PPS.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

COBRA, enacted April 7, 1986, contained numerous provisions that affected Medicare beneficiaries, providers, physicians, intermediaries and carriers. Following is a brief discussion of some of the law's principal provisions relating to health care issues.

Medicare Reimbursement and Benefit Changes

During the final 5 months of FY 1986, COBRA provided for an increase of 0.5 percent for PPS hospitals and a 5/24ths of 1 percent increase for hospitals and health care units not covered by PPS. For fiscal years 1987 and 1988, the rate of increase would be no greater than the increase in the hospital marketbasket of prices.

COBRA provides that the indirect teaching adjustment factor will be reduced from 11.59 percent to 8.1 percent for discharges occurring from May 1, 1986, to September 30, 1988, and to 8.7 percent for discharges thereafter.

In replacing the methodology for payments to hospitals for their direct cost for graduate medical education, the Act further provides that payment will be determined based on hospital-specific per resident amounts. Payment limits would be the hospital's approved full-time-equivalent (FTE) amounts during the first PPS year (FY 1984) cost-reporting periods and would be updated to 1985-86 for hospitals not on a July 1 cost-reporting year.

COBRA continues the waiver for hospitals operating an approved cost control system, as long as the waiver has been approved by the Secretary and other requirements are met, and extends the test period of a State's system of reimbursement for a waiver of Medicare's reimbursement rules for an additional 12 to 48 months.

COBRA requires HHS to study the impact of the outlier and transfer policies under PPS on rural hospitals, particularly those with fewer than 100 beds. It also provides for a 1-year extension of PPS transition, requires the Secretary to implement a new "gross wage index," provides for an adjustment in the Federal portion of the DRG payment for hospitals serving a disproportionate share of low-income patients, provides a payment adjustment for sole community hospitals that experience a significant increase in operating costs attributable to the addition of new inpatient facilities or services, and lowers the discharge criteria for osteopathic hospitals to qualify for rural referral center status.

COBRA phases out return-on-equity capital payments for inpatient hospital services over 3 years, eliminating all payments by FY 1990. It further provides that the rate of return for SNFs and other providers will be reduced to the interest rate paid on the HI Trust Fund effective October 1, 1985.

COBRA requires the Senate Committee on Finance to report legislation which will reform calculation of the annual increase in the Part A deductible. The Act also requires that the notice of the projected increase be published by September 15 of each year.

COBRA repeals the sunset provision for hospice care, sets the routine home care daily rate of payment at $63.17 per day, and increases the daily rate of payment for other services by $10.

Beginning October 1, 1986, SNFs providing less than 1,500 days of care per year have the option of being paid a prospective rate set at 105 percent of the regional mean for all SNFs in the region.

Beginning in 1987, the annual clinical laboratory fee schedules are to be updated on January 1 rather than July 1; the January 1, 1987, update must take into account the change in the Consumer Price Index for all urban consumers occurring over the preceding 18-month period. A ceiling is established to be applied to carrier fee schedule amounts on a test-by-test basis. COBRA also mandates assignment for physician-office laboratories and beneficiary coinsurance and deductibles waived.

In other provisions, COBRA:

- Extends Medicare coverage on a mandatory basis for all State and local government employees hired after March 31, 1986.
- Extends the working aged provision to cover workers and their spouses beyond the age of 69.
- Limits the penalty for late enrollment for those uninsured aged who voluntarily enroll in Part A.

- Extends the requirement that the supplementary medical insurance (SMI) premium continue to be based on 25 percent of program costs for beneficiaries through calendar year 1988.

COBRA provisions affecting physicians include:

- An extension of the freeze on customary and prevailing charges and nonparticipating physicians' actual charges through April 30, 1986. The Act also extends existing participating agreements for an additional 3 months, October to December 1986, and permits physicians to sign voluntary participation agreements for an 8-month period, May 1 to December 31, 1986.

- For the period of May 1 to December 31, 1986, an increase in participating physicians' prevailing charges of 1 percent more than the MEI that would otherwise be in effect; extension of the freeze on nonparticipating physicians' customary, prevailing and actual charges; and a clause limiting dropout physicians to the customary charge update only -- their actual charges are frozen at the April-June 1984 levels.

- An advance from October 1 to January 1 of the date for updating participating physicians' customary charges and prevailing charges; nonparticipating physicians will also receive customary charge updates on January 1, but will be subject to prevailing charge levels applied to participating physicians in the previous year. The freeze on actual charges expires on December 31, 1986.

- A limit on payments for post-cataract surgery and allowance of payments for assistants at surgery for certain operations only when approved by a PRO.

- A mandate that HHS develop a relative value scale for physician services.

- A provision that all participating hospitals with emergency departments must provide an appropriate medical screening examination or treatment for an individual who requests it.

- A mandate that PROs perform 100 percent review of certain surgical procedures, require second surgical opinions in certain cases and deny payments for those cases where second opinions were not obtained. It further permits PROs to deny payment for services determined to be substandard.

- A specification that PROs review HMOs and CMPs.

Tables 18, 19, and 20 detail laws affecting Medicare.

Table 18. Major Medicare-related public laws.

Title	Public law number	Date of enactment	Major provisions
Balanced Budget and Emergency Control Act of 1985 (Part of Joint Resolution Public Debt)	P.L. 99-177	12/12/85	- Establishes budget deficit reduction targets each year through 1990 in order to eliminate the deficit. - Imposes deadlines to bring a budget resolution, appropriation bills and reconciliation in line with budget targets or a sequestration process begins. - Establishes a special 2% sequestration for the Medicare program. Social Security benefits are exempt.
Departments of Labor/ HHS/Education and Related Agencies Appropriation Act of 1986	P.L. 99-178	12/12/85	- Appropriates $18.854 billion for payments to the Medicare Trust Fund. - Sets aside $15 million to be used to process workloads and cover costs which were not anticipated in administering Title XVIII.
Consolidated Omnibus Budget Reconciliation Act of 1985	P.L. 99-272	04/02/86	- Limits increases in doctor and hospital Budget Reconciliation charges. - Extends Medicare coverage on a mandatory basis for all State and local government employees hired after March 31, 1986. - Extends the "working aged" provision to workers and their spouses beyond age 69. - Extends requirement that SMI premium offset 25 percent of program costs. - Phases out return-on-equity capital payments for inpatient hospital services by 1990. - Repeals sunset provision for hospice care.
Urgent Supplemental Appropriations Act of 1986	P.L. 99-366	07/02/86	- Delays the incorporation of capital-related costs of hospitals into PPS system.
Ratification of Sequestration Order	P.L. 99-366	07/31/86	- Reaffirms as law the 2/1/86 sequestration order of the President.

Table 19. Emergency extension laws.

Title	Public law number	Date of enactment	Major provisions
Emergency Extension Act of 1985	P.L. 99-107	09/30/85	- Extended the hospital payment rate at FY 1985 levels through Nov. 14, 1985. - Extended the physician fee freeze established in DEFRA through Nov. 14, 1985.
To Temporarily Increase the Limit on the Public Debt and Restore Investments of the SS Trust Fund	P.L. 99-155	11/14/85	- Extended the hospital payment rate and physician fee freeze as noted above through Dec. 14, 1985.

Table 20. Other laws of interest.

Title	Public law number	Date of enactment	Major provisions
Continuing Appropriations, FY 1986	P.L. 99-103	09/30/85	- Provided funding for HHS programs from Oct. 1 through Nov. 14, 1985.
Continuing Appropriations, FY 1986	P.L. 99-154	11/14/85	- Provided funding for HHS programs from Nov. 15 through Dec. 19, 1987.
Health Services Amendments of 1985	P.L. 99-117	10/07/85	- Makes special provisions for alcohol and drug abuse services for women, children and underserved populations.

Table continues on next page.

Table 20. Other laws of interest (continued).

Title	Public law number	Date of enactment	Major provisions
Health Research Extension Act of 1985	P.L. 99-158	11/20/85	- Authorizes NIH programs for 3 years; provides more explicit statutory authority for NIH in order to strengthen their programs. - Orders a study of health personnel required to meet needs of the elderly over next four decades.
Health Professions Training Assistance of 1985	P.L. 99-129	10/22/85	- Reauthorizes educational assistance to health professionals with emphasis on continuing support for family physician programs and those targeting minorities and rural areas.
Protection and Advocacy for Mentally Ill Individuals Act, 1986	P.L. 99-319	05/23/86	- Requires HHS and State survey agencies to provide the State's advocacy system for the mentally ill with copies of annual survey reports performed under Titles XVIII and XIX.
To Extend Application of Certain Tobacco Excise Taxes and Medicare Reimbursement Provisions	P.L. 99-181	12/13/85	- Extended the hospital payment rate and physician fee freeze through Dec. 18, 1985.
To Extend Application of Certain Tobacco Excise Taxes and Medicare Reimbursement Provisions	P.L. 99-189	12/18/85	- Extended the hospital payment rate and physician fee freeze through Dec. 19, 1985.
To Extend Application of Certain Tobacco Excise Taxes and Medicare Reimbursement Provisions	P.L. 99-201	12/23/85	- Extended the hospital payment rate and physician fee freeze from Dec. 19, 1985, through March 14, 1986.

Chapter VIII.

SIGNIFICANT REGULATIONS PUBLISHED IN FY 1986

LIMITATIONS ON THE REIMBURSEMENT OF NONPHYSICIAN MEDICAL SERVICES

The reasonable-charge method used to determine reimbursement for Part B services has been criticized as an inherently inflationary system because actual charges, which have continued to increase steadily over time, affect each subsequent year's reasonable charges. The rule establishes an additional charge factor to be considered in determining reasonable charges for nonphysician services, supplies and equipment that are reimbursed on a reasonable charge basis. This new factor will represent the reasonable charge from the preceding fee screen year plus an inflation adjustment factor. For fee screen years beginning on or after October 1, 1986, the inflation adjustment factor will be the annual change in the level of the consumer price index for urban consumers for the 12-month period ending on March 31. For the fee screen years beginning on October 1, 1985, the inflation adjustment factor will be zero.

Date of Publication: October 1, 1985.

ASSIGNMENT AND REASSIGNMENT OF HOME HEALTH AGENCIES TO DESIGNATED REGIONAL INTERMEDIARIES

The regulation announces which fiscal intermediaries are designated as regional intermediaries to service all freestanding home health agencies.

Date of Publication: February 13, 1986

PAYMENT FOR COSTS OF MALPRACTICE INSURANCE FOR HOSPITALS AND SKILLED NURSING FACILITIES

This rule amends the method for determining reasonable cost reimbursement for the costs of malpractice insurance incurred by hospitals and skilled nursing facilities (SNFs). HCFA proposed the retention of the claim-paid formula whereby a hospital or SNF is reimbursed according to the ratio of its malpractice claims paid to all patients. A hospital or SNF with no malpractice claims-paid experience will be reimbursed on an amount equal to a national ratio of malpractice claims paid to Medicare patients compared to malpractice claims paid to all patients. In addition, the Agency proposes to update the national ratio used to determine the amount payable to hospitals with no loss experience.

Date of Publication: April 1, 1986

RECOGNITION OF STATE REIMBURSEMENT CONTROL SYSTEMS

The rule implements statutory requirements to set forth conditions and procedures under which HCFA will approve Medicare payments for hospital services to be made in accordance with a State hospital reimbursement control system rather than in accordance with general Medicare principles of reimbursement.

Date of Publication: April 24, 1986.

SURVEY AND CERTIFICATION PROCEDURES

This regulation streamlines, simplifies and integrates survey and certification procedures for providers and suppliers under Medicare and Medicaid. It is intended to accomplish effective monitoring with greater flexibility to States without loss of quality of health services.

Date of Publication: June 13, 1986

CONDITIONS OF PARTICIPATION FOR HOSPITALS

This regulation simplifies requirements which hospitals must meet to be certified to participate in Medicare and Medicaid. It is intended to reduce Federal requirements, simplify and clarify regulations and provide maximum flexibility in hospital administration while strengthening patient health and safety. It also makes Medicare regulations conform to statutory changes made by P.L. 98-369 regarding certification of psychiatric and tuberculosis hospitals.

Date of Publication: June 17, 1986

INTERMEDIATE SANCTIONS OF LONG-TERM CARE FACILITIES

This regulation authorizes the Secretary and State Medicaid agencies to impose an alternative to terminating long-term care facilities found to be out of compliance with the Medicare conditions of participation or standards in facilities where deficiencies do not pose an immediate jeopardy to patient health and safety. HCFA and the State Medicaid agency may deny payment for new admissions to the facilities.

Date of Publication: July 3, 1986

PROCESSING OF CLAIMS BY ELECTRONIC MEANS AS A CONDITION OF QUALIFICATION FOR THE PERIODIC INTERIM PAYMENT METHOD OF REIMBURSEMENT

Many providers currently under the Periodic Interim Payment (PIP) method continue to submit claims in hard-copy because there is no incentive to submit bills electronically. This regulation requires that providers submit claims for Medicare payment electronically to qualify for periodic interim payments. This requirement will increase the accuracy and efficiency of Medicare claims processing and result in a significant reduction in administrative costs.

Date of Publication: August 15, 1986

MEDICARE PROGRAM: CHANGES TO THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM AND FISCAL YEAR 1987 RATES

The regulation implements necessary changes in the inpatient hospital prospective payment system arising from legislation and HCFA's continuing experience with the system.

In addition, the regulation describes changes in the methods, amounts and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. In general, these changes apply to discharges occurring on or after October 1, 1986. The regulation also sets forth the update factor for determining the rate-of-increase limits for hospitals excluded from the prospective payment system.

Date of Publication: September 3, 1986

LIMITATION ON PAYMENT FOR SERVICES FURNISHED TO EMPLOYED AGED AND TO AGED SPOUSES OF EMPLOYED INDIVIDUALS

These regulations amend the rules dealing with the Medicare "working aged" provision. They set forth policies and procedures under which Medicare is secondary payer for health care items and services furnished to employed individuals age 65 through 69 and spouses age 65 through 69 who are covered under employer group health plans of employers which employ 20 or more employees. The regulations clarify the circumstances in which Medicare is secondary and clarify the definition of employer group health plan by providing that this term encompasses multiemployer plans and employee-pay-all plans.

These regulations also incorporate provisions of the Deficit Reduction Act of 1984 (P.L. 98-369) enacted July 18, 1984, which modifies application of these rules to employees' spouses age 65 through 69 and changes the age limit for individuals subject to the secondary payer provisions to the month before the month the individual attains age 70.

Date of Publication: October 11, 1985.

Chapter IX.

REPORTS AND PUBLICATIONS

HCFA publishes an array of reports and publications dealing with the Medicare program. Those publications listed in this chapter may be of particular interest to members of Congress as well as to the public.

ORDERING INFORMATION

Except where noted, single copies of the following beneficiary publications are available from local Social Security Administration offices or by written request to:

Health Care Financing Administration
Office of Public Affairs (OPA)
Room 658 East High Rise Building
6325 Security Boulevard
Baltimore, 21207

Research and Demonstrations (R&D) -- Placement on the mailing list, for notification of all R&D reports as they are published, and single complimentary copies of publications, with the exception of the HCFA Review, are available by written request from:

Health Care Financing Administration
Office of Research and Demonstrations (ORD)
Publications and Information Resources
Room 1-A-9 Oak Meadows Building
6340 Security Boulevard
Baltimore, 21207

What You Should Know About Medicare (ICN 460000, SSA-05-10043, January 1987). A pamphlet describing the basic aspects of Medicare including coverage, deductibles, coinsurance and eligibility requirements.

Your Medicare Handbook (ICN 000181, HCFA-10050). A comprehensive explanation of the Medicare program for Medicare beneficiaries.

Guide to Health Insurance for People with Medicare (487790, HCFA-02110, 1987). A consumer-oriented pamphlet for Medicare beneficiaries which discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare and hints on shopping for private health insurance.

Medicare and Employer Health Plans (ICN 488331, HCFA 02150, 1986). The pamphlet explains the law which requires employers to offer employed Medicare beneficiaries age 65 or older the same health insurance plan that they offer to their younger employees.

Medicare and Prepayment Plans (488339, HCFA 02150, 1986). A pamphlet describing kinds of HMOs and what health services they offer.

Your Hospital Stay Under Medicare's Prospective Payment System (PPS) (ICN 488334, HCFA 02150, 1986). A pamphlet describing the Prospective Payment System, Diagnosis Related Groups (DRGs) and Peer Review Organizations (PROs).

Hospice Benefits Under Medicare (ICN 487973, HCFA 02154, 1986). A pamphlet describing the special rules of coverage for care in a hospice.

Beneficios de Hospicio Bajo Medicare (ICN 488332, HCFA 02162, 1986). A Spanish version of Hospice Benefits Under Medicare.

Thinking of Having Surgery? Think About Getting A Second Opinion (ICN 487793, HCFA-02114, 1982). A brochure addressing the advisability of seeking a second medical opinion before agreeing to any non-emergency surgery. It outlines questions you should ask, when to get a second opinion, how to find a specialist to give a second opinion and how to pay for a second opinion.

Medicare and You (ICN 443504, HCFA 00009, 1987). Scriptographic Booklet. This booklet explains what Medicare is, what it covers and pays and how to qualify for Medicare.

Report on Hospital Wage Index (HCFA, March 1985). This report describes the differences in wages from area to area by the labor-related portion of the Federal prospective payment rates. The report also contains the results of the HCFA wages survey and two new wage indexes based on that survey. (Available from NTIS)

Medicare and Medicaid (There is a Difference!) (ICN 443514, HCFA 0019, 1987). Scriptographic Booklet. This booklet explains the difference between Medicare (an insurance program) and Medicaid (an assistance program).

Health Status of Aged Medicare Beneficiaries. This report provides descriptive information from the National Medical Care Utilization and Expenditure Survey about selected aspects of the health status of noninstitutionalized elderly people covered by Medicare, including measures of disability, activity limitation, illness conditions, and perceived health status. (Available from ORD.)

Access to Health Care Among Aged Medicare Beneficiaries. This report provides descriptive information from the National Medical Care Utilization and Expenditure Survey about selected aspects of access to health care among noninstitutionalized elderly people covered by Medicare, including regular source of care, physical access to the regular source, insurance coverage, and the existence of medically unattended conditions. (Available from ORD.)

Several publications series covering research and demonstration activities and statistical information on the Medicare and Medicaid programs were part of a dissemination effort to reach interested user groups and to provide research results for policymakers and health professionals.

- Health Care Financing Program (Brown Series). Report indepth information on Medicare and Medicaid program operation and use, including data on enrollment, utilization, providers, reimbursement and recipients.

- Health Care Financing Research Reports (Purple Series). Report on major intramural studies and projects conducted by HCFA. Contain significant findings that affect HCFA programs and serve as a basis for making program changes.

- Health Care Financing Grants and Contracts Reports (Blue Series). Provide final reports on extramural projects funded by HCFA/ORD. Topics include hospital cost containment, long-term care reform, physician reimbursement, beneficiary access to and use of services and health systems organizations.

- National Medical Care Utilization and Expenditure Survey Reports (Rust Series). Report on survey findings, including information on access to and use of medical care, health and demographic characteristics of persons and families and the sources and costs of services.

- Health Care Financing Special Reports (Orange Series). Report on single themes, providing comprehensive coverage of an important issue in health care financing.

- Status Report: Research and Demonstrations Health Care Financing (Red Series). Provide basic information in a brief format on the more than 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

- Health Care Financing Notes (Black on White Series). Provide brief and concise reports that present data highlights on various aspects of the Medicare and Medicaid programs.

- Health Care Financing Project Reports (Black on Buff Series). Include brief reports on individual research and demonstration projects that provide an overview of the project and major findings or results and include information on obtaining related publications.

- Health Care Financing Review (Green Quarterly Plus Annual Supplement). HCFA's quarterly research journal, reports findings related to health care financing. Includes trends data that highlight economic developments in the health care sector and announcements of new HCFA research publications and projects.

Additional information on the research publications program and the availability of various reports may be obtained from the ORD Publications and Information Resources Branch, Room 1-A-9 Oak Meadows Building, 6325 Security Boulevard, Baltimore, 21207.

Other publications and technical manuals are available for a fee by writing or phoning:

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Chapter X

REPORT ON MEDICARE VALIDATION SURVEYS OF HOSPITALS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH): Fiscal Year 1986

INTRODUCTION

The purpose of the validation program is to evaluate the effectiveness of the Joint Commission on Accreditation of Hospitals (JCAH) accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare Conditions of Participation. Each year, the Health Care Financing Administration (HCFA) selects a statistical sample from the approximately 5,100 JCAH accredited hospitals for validation surveys. Under contract with the Secretary, State agencies (SAs) conducted 48 validation surveys during this report period (FY 86).

STATUTORY BACKGROUND

Section 1865 of the Social Security Act provides that JCAH accredited hospitals are deemed to meet the requirements of the Medicare conditions of participation, except for utilization review or other standards the Secretary promulgates that are higher than JCAH standards. Thus, JCAH accredited hospitals are not subject to annual SA surveys to assess compliance with the conditions of participation. Subsection 1B64(c) of the Act authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by JCAH on a selective sample basis or in response to substantial allegations of significant deficiencies that affect the health and safety of patients.

ACCREDITATION PROCESS

The purpose of a JCAH accreditation survey is to assess the extent of a hospital's compliance with the JCAH standards. After the completion of the on-site survey, JCAH makes an accreditation decision. Prior to January 1, 1982, the maximum accreditation period for hospitals fully meeting JCAH standards was 2 years. If JCAH found a hospital in substantial compliance with its standards, although demonstrating certain shortcomings, the hospital received 1-year accreditation. On January 1, 1982, JCAH discontinued both 1- and 2-year terms by changing its program to a 3-year accreditation with a "contingency" procedure. Under JCAH's new program, a hospital may receive a 3-year accreditation with a contingency or, in cases where a hospital fails to achieve substantial overall compliance, no accreditation. A contingency stipulates that the accreditation will be withdrawn if the hospital fails to correct its deficiencies within a specified amount of time. JCAH, through the

use of focused on-site resurveys and/or written reports prepared by the hospital, determines whether the hospital has corrected the deficiencies necessary to retain accreditation. The contingency accreditation process is analogous to a Medicare resurvey as they both assess correction of deficiencies. If corrections are not completed as specified in the contingency, the hospital may be dropped from the program. When JCAH increased its accreditation cycle to 3 years, it strengthened existing monitoring mechanisms to include periodic self-survey reports and/or focused on-site surveyor revisits.

VALIDATION AND ALLEGATION PROCESS

The HCFA selects from scheduled JCAH surveys a statistical sample of accredited hospitals for validation surveys. The random selection reflects an urban-rural mix of hospitals and a range of different size hospitals. As a result, findings reflect the universe of JCAH hospitals. State agencies (SAs) survey these hospitals using the Medicare Conditions of Participation for Hospitals.

In addition to the sample hospitals, an accredited hospital is also subject to a SA survey when there is an allegation that significant deficiencies threaten the health and safety of patients. Allegation surveys evaluate only the specified condition(s) as authorized by HCFA's regional offices. If the SA finds a significant deficiency in the specified condition(s), the investigation is expanded to a full survey.

In both sample and allegation surveys, if the SA finds significant deficiencies, the hospital is placed under SA surveillance until the deficiencies are corrected. The hospital is no longer deemed to meet the Medicare Conditions of Participation and the SA monitors the correction of any deficiency as if the hospital were unaccredited.

In this report period JCAH made 992 accreditation decisions for hospitals. Six percent of these hospitals (58 of 992) received 3-year accreditations without contingencies, 72 percent (714 of 992) received accreditations requiring written contingency reports, 2 percent (16 of 992) received accreditations requiring contingency on-site visits and 20 percent (198 of 992) received contingencies requiring both written reports and on-site visits. Six tenths of a percent (6 of 992) were not accredited. Ninety-four percent of all accredited hospitals surveyed by JCAH during 1986 received contingencies (72 percent + 2 percent + 20 percent) as compared to 90 percent of the validated hospitals.

Analysis was conducted in two discrete areas: Life Safety Code and general health and safety requirements.

Life Safety Code (LSC)

The LSC of the National Fire Protection Association is a consensus standard adopted by reference in Federal regulations which provides a reasonable level of safety from fire and other emergencies. During this report period, 93 percent (46 of 48) of validated hospitals were in compliance with the LSC (See Table 21). For all hospitals validated prior to this report period, 49 percent (428 of 879) were in compliance with LSC. This increase in LSC compliance can be attributed to Medicare's adoption of the Fire Safety Evaluation System (FSES) for validation surveys and the improved effectiveness of JCAH surveyors in assessing compliance with the LSC by using the 1981 code. The FSES was developed by the National Bureau of Standards and is a method for assessing compliance with LSC requirements. The FSES permits a facility to employ alternative measures for meeting LSC requirements while providing an equivalent level of fire safety. Since adoption of the FSES there is more similarity between the JCAH and Medicare LSC surveys because we are both using the FSES. Also, this year JCAH surveyed all facilities for compliance with the 1981 Code. The 1981 Code relies more heavily on early detection and prompt notification of the fire department than earlier codes.

JCAH cited many deficiencies for inadequate smoke barriers. These types of deficiencies could prove to be serious, especially in buildings without sprinkler systems. There were also Medicare citations without corresponding JCAH citations for unprotected vertical openings and lack of firestopping material.

Over the years JCAH surveyors have increased citations pertaining to integrity of doors, walls, ducts and smoke barriers and continue to cite those important deficiencies. There were few deficiencies cited by Medicare that were not also noted by JCAH surveyors. This demonstrates increased equivalency as a result of previous recommendations.

Table 21. Validation surveys - FY 1986:

Accredited hospitals found in compliance by Medicare state survey agencies.

	All previous report periods		Current report period FY 1986	
	Frequency	Percent	Frequency	Percent
General health & safety:				
In compliance	797	91	40	83
Total surveys	879		48	
Life safety code:				
In compliance	428	49	46	93
Total surveys	879		48	

General Health and Safety

Revised Medicare Conditions of Participation for hospitals became effective September 15, 1986. These regulations simplify and clarify Federal requirements, provide flexibility in hospital administration, and enhance patient safety. At the same time, they emphasize results rather than processes, promote cost-effectiveness while maintaining quality of care, and are a more effective for enforcing compliance with Federal requirements. Some of the requirements included in the revised conditions of participation are new; others are not. The new requirements are indicted by an asterisk in Table 22. The frequency of non-compliance by hospitals (see Table 22) was evenly distributed over the conditions, occurring between 0 and 4 times in the sample group (0% to 8%). In the universe of unaccredited hospitals (1,035) the frequency of non-compliance was also distributed evenly over the conditions, occurring between 0 and 57 times (0% to 6%).

During this report period, 83 percent (40 of 48) of JCAH accredited hospitals receiving validation surveys were found in compliance with Medicare's general health and safety conditions (see Table 21). This is consistent with the range of percentages in compliance (80% to 96%) in all previous report periods.

Substantial Allegation Findings

For this report period, State agencies surveyed 402 hospitals based on allegations of significant deficiencies that could affect the health and safety of patients. For the second consecutive year, HCFA found 11 percent of the surveyed hospitals (45 of 402) out of compliance with one or more conditions. As in the previous year, 4 percent (15 of 402) were out of compliance in nursing.

For all other general health and safety conditions the frequency of non-compliance ranged from 4 percent to 0 percent.

CONCLUSIONS

For both validation surveys and complaint investigations, State agencies found that 88 percent of all hospitals surveyed were found in compliance with all conditions (397 of 450). In recent years, the proportion of hospitals found in compliance with all conditions in both surveys has ranged from 80 percent for FY 1985 and 80 percent for FY 1984 to 85 percent for FY 1983, demonstrating continued equivalency between the JCAH and Medicare survey processes.

Table 22. Sample non-compliance compared to unaccredited universe non-compliance - FY 1986.

Condition	Sample non-compliance		Unaccredited sample universe 1035 non-compliance	
	Frequency	Percent	Frequency	Percent
State and local law	3	6	36	3
Governing body	3	6	41	4
Quality assurance	*	*	*	0*
Medical staff	1	2	32	3
Nursing services	1	2	28	3
Medical records service	0	0	21	2
Pharmaceutical services	3	6	43	4
Radiologic services	0	0	12	1
Laboratory service	4	8	57	6
Food and dietetic service	2	4	19	2
Physical environment	1	2	44	4
Infection control	*	*	0*	*
Optional Services:				
Surgical services	*	*	0	*
Anesthesia services	*	*	*	*
Nuclear medicine services	*	*	*	*
Outpatient services	1	2	11	1
Emergency services	0	0	1	6
Rehabilitation services	*	*	*	*
Respiratory care services	*	*	*	*

* New Conditions Effective September 15, 1986.

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